Supreme Court, U.S.
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No.

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1998

LUCIANO MONTALVO, INDIVIDUALLY AND AS THE PARENT AND GUARDIAN OF MICHAEL MONTALVO,
Petitioner,

v.

JAMES P. RADCLIFFE, II AND SOUTHSIDE VIRGINIA POLICE KARATE ASSOCIATION, INCORPORATED, D/B/A U.S.A. BUSHIDOKAN,
Respondent.

On Petition for Writ of Certiorari to the
United States Court of Appeals for the Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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May 12, 1999

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QUESTIONS PRESENTED FOR REVIEW

I. Where the parties stipulated at trial that Petitioner was a person with a "disability" and Respondent was a "place of public accommodation" within the meaning of the Americans With Disabilities Act, 42 U.S.C. § 12101 *et seq.*, did the Fourth Circuit improperly hold that Respondent was entitled to exclude Petitioner absent a qualified medical opinion that his HIV-positive status posed a "significant risk" to others?

II. Where the parties stipulated at trial that Petitioner was a person with a "disability" and Respondent was a "place of public accommodation" within the meaning of the Americans With Disabilities Act, 42 U.S.C. § 12101 *et seq.*, did the Fourth Circuit improperly base its opinion upon expert testimony that amounted to unquantified speculation on the theoretical possibility of transmission of HIV infection, contrary to the standards enunciated by this Court in *Bragdon v. Abbott*, 524 U.S. 624 (1998)?

III. Where the parties stipulated at trial that Petitioner was a person with a "disability" and Respondent was a "place of public accommodation" within the meaning of the Americans With Disabilities Act, 42 U.S.C. § 12101 *et seq.*, did the Fourth Circuit improperly conclude that a "reasonable modification" in Respondent's program was offered under the Americans With Disabilities Act, 42 U.S.C. § 12182, when said "modification" consisted of completely segregating and isolating Petitioner from the other students in the school?

TABLE OF CONTENTS

QUESTIONS PRESENTED FOR REVIEW.....i

TABLE OF AUTHORITIES.....vii

OPINIONS BELOW.....2

JURISDICTION.....2

RELEVANT STATUTES AND REGULATIONS.....2

STATEMENT OF THE CASE.....2

A. Statement of the Facts.....2

B. Proceedings and Decisions in the Courts Below.....3

REASONS FOR GRANTING THE WRIT.....5

I. THE FOURTH CIRCUIT COURT OF APPEALS HAS DECIDED ON FIRST IMPRESSION AN IMPORTANT QUESTION UNDER TITLE III OF THE AMERICANS WITH DISABILITIES ACT, 42 U.S.C. § 12182 (1990), IN A MANNER AT ODDS WITH THE READING OF PARALLEL PROVISIONS OF THE ADA BY THIS COURT AND OTHER FEDERAL

COURTS
.....5

A. The Fourth Circuit's Decision Is a Case of First Impression Concerning the Important Issue of the Application of the Americans With Disabilities Act to the Exclusion of an HIV-Positive Individual by the Operator of a Public Accommodation in the Nature of a Recreational Program or Facility
.....5

1. The Fourth Circuit's decision is a case of first impression in the federal system on the important issue of access of HIV-positive individuals to recreational and athletic public accommodations
.....5

2. Ensuring access to recreational and athletic public accommodations is critical to the purpose and letter of the Americans With Disabilities Act to eradicate unfounded discrimination against HIV-positive individuals.
.....6

a. HIV/AIDS Progression.....9

b. HIV/AIDS Transmission.....12

B. The Fourth Circuit's Decision is at Odds With the Pronouncements of this Court and Other Circuits Regarding the Requisite

Standard of Proof to Establish Whether a Disabled Person Posed a "Direct Threat" to Others.
.....14

1. Respondent unilaterally excluded Petitioner despite the medical opinion of Petitioner's treating physician that he posed no danger to himself or others, and without countervailing objective medical evidence to the contrary, in derogation of the standards established by this Court in *School Board of Nassau County v. Arline* and *Bragdon v. Abbott*
.....14

2. The district court improperly refused to permit any quantified assessment by testifying medical experts of the level of risk of transmission of HIV to the instructors and students in U.S.A. Bushidokan, instead improperly relying upon unquantified speculation about the possibility of transmission, in derogation of the standards established by this Court in *School Board of Nassau County v. Arline* and *Bragdon v. Abbott*, and analogous decisions of other federal circuits under the ADA.
.....16

3. The Court of Appeals improperly held that Respondent's offer of isdation of Petitioner via a one-on-one instructional program was

a "reasonable accommodation" of his disability.
.....24

II. THIS CASE IS APPROPRIATE FOR REVIEW BY A GRANT OF CERTIORARI, VACATION AND REMAND IN LIGHT OF THIS COURT'S DECISION IN *BRAGDON V. ABBOTT*.
.....27

CONCLUSION.....30

APPENDIX.....A1 et seq.

TABLE OF AUTHORITIES

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Doe v. DeKalb County, 145 F.3d 1441 (11th Cir. 1998).....24

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28 U.S.C.§ 1254(1).....2

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42 U.S.C. §§ 12181 - 12182 Americans With Disabilities Act, Title 42, Chapter 126, United States Code Service.....*passim*

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No.

In The
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Respondent.

On Petition for Writ of Certiorari to the
United States Court of Appeals for the Fourth Circuit

TO THE HONORABLE CHIEF JUSTICE AND ASSOCIATE JUSTICES OF THE SUPREME COURT OF THE UNITED STATES:

Petitioner Luciano Montalvo, for Michael Montalvo, a minor, respectfully petitions for a writ of *certiorari* to review the decision of the United States Court of Appeals for the Fourth Circuit affirming the judgment of the United States District Court for the Eastern District of Virginia that Respondent U.S.A. Bushidokan, a karate school operating as a "place of public accommodation" within the meaning of the Americans With Disabilities Act (42 U.S.C. § 12181(7)), was

not required by the Act to enroll Michael Montalvo because his disability -- Acquired Immunodeficiency Syndrome -- posed a "direct threat" to the health and safety of students in the school.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit, *Montalvo v. Radcliffe*, 167 F.3d 873 (4th Cir. 1999), is included in the Appendix hereto at A1 - A15. The unpublished Final Order and Findings of Fact and Conclusions of Law of the United States District Court for the Eastern District of Virginia, *Montalvo v. Radcliffe*, Civil No. 3:97CV487 (January 29, 1998), 1998 U.S. Dist. LEXIS 4885, is included in the Appendix hereto at A33 - A49.

JURISDICTION

The Petitioner seeks review by writ of *certiorari* from the decision of the Fourth Circuit Court of Appeals entered February 12, 1999. Jurisdiction is conferred upon this Court pursuant to 28 U.S.C. § 1254(1).

RELEVANT STATUTES AND REGULATIONS

Set out in the Appendix hereto are relevant provisions of the Americans With Disabilities Act, Title 42, Chapter 126, United States Code Service, 42 U.S.C. §§ 12181 - 12182. Appendix at A50- A58.

STATEMENT OF THE CASE

A. Statement of the Facts

Petitioner Michael Montalvo is a child with Acquired Immunodeficiency Syndrome ("AIDS"), which constitutes a "disability" within the meaning of the Americans With Disabilities Act, 42 U.S.C. 12111(8)(1990). App. at 42. Luciano Montalvo, Michael's father, attempted to enroll Michael in karate classes at defendant karate school, U.S.A. Bushidokan. App. at 37-39. U.S.A. Bushidokan personnel learned of Michael's condition and refused to allow Michael to participate in karate classes. App. at 39. U.S.A. Bushidokan personnel offered private lessons to Michael in lieu of participation in classes with the other students. *Id.* Michael's father rejected this proposal, since it defeated his purpose to integrate Michael in social activities with other children to help Michael live a normal young person's life to the extent possible. *Id.*; App. at 88. Petitioner U.S.A. Bushidokan claimed, and the District Court found, that Michael's participation in classes put other class participants in "grave danger of contracting HIV and/or AIDS." App. at 44.

B. Proceedings and Decisions in the Courts Below

The Montalvos filed suit under the Americans With Disabilities Act of 1990 ("ADA"), 42 USC § 12101 *et seq.*, and the Virginians With Disabilities Act, Va. Stats. § 51.5 *et seq.*,[1] seeking an injunction requiring U.S.A. Bushidokan to admit Michael Montalvo as a student and for compensatory damages, costs and attorneys fees. App. at 71 - 72. Pursuant to Stipulations of Fact filed on January 16, 1998, the parties

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[1] Petitioner's Amended Complaint stated two counts, the first under the Americans With Disabilities Act and the second under the Virginia Persons With Disabilities Act. App. at 69. For purposes of this Petition, only issues arising under the ADA will be presented.

stipulated, *inter alia*, that U.S.A. Bushidokan was a place of entertainment and recreation which was a "gymnasium . . . or other place of exercise or recreation" and thus constituted a place of "public accommodation" pursuant to the ADA, 42 U.S.C. § 12181(L); that Respondent would not allow Michael Montalvo to participate in karate classes at U.S.A. Bushidokan because they believed he was infected with HIV or had AIDS; and that Respondent offered to allow Michael to have private lessons. App. at 74 - 75.

Cross motions for summary judgment were filed by both parties, App. at 62, 63, and denied by the court. App. at 64. After a one and one-half hour trial held on January 22, 1998, App. at 64, the United States District Court for the Eastern District of Virginia, Richmond Division, found, *inter alia*, that allowing Michael Michael to train in group classes at U.S.A. Bushidokan would place the students, instructors, and all other relevant participants in "grave danger" of contracting HIV and/or AIDS, and that the accommodation of private lessons offered by U.S.A. Bushidokan was reasonable. App. at 44 - 48, paras. 7 - 8. The court denied the Montalvos' claims with prejudice and granted judgment for U.S.A. Bushidokan. App. at 33, 49.

The Montalvos appealed the decision of the District Court, entered on January 29, 1998, by timely Notice of Appeal filed on February 5, 1998. App. at 65. After oral hearing held October 26, 1998, App. at 16 - 32 (Transcript of Oral Argument), the United States Court of Appeals for the Fourth Circuit affirmed the judgment of the District Court, holding that "the nature of the risk, combined with its severity, creates a significant risk to the health and safety of hard-style karate class members." *Montalvo v. Radcliffe*, 167 F.3d 873, 878 (4th Cir. 1999), App. at 10 - 11.

REASONS FOR GRANTING THE WRIT

I. THE FOURTH CIRCUIT COURT OF APPEALS HAS DECIDED ON FIRST IMPRESSION AN IMPORTANT QUESTION UNDER TITLE III OF THE AMERICANS WITH DISABILITIES ACT, 42 U.S.C. § 12182 (1990), IN A MANNER AT ODDS WITH THE READING OF PARALLEL PROVISIONS OF THE ADA BY THIS COURT AND OTHER FEDERAL CIRCUITS.

A. The Fourth Circuit's Decision Is a Case of First Impression Concerning the Important Issue of the Application of the Americans With Disabilities Act to the Exclusion of an HIV-Positive Individual by the Operator of a Public Accommodation in the Nature of a Recreational Program or Facility.

1. The Fourth Circuit's decision is a case of first impression in the federal system on the important issue of access of HIV-positive individuals to recreational and athletic public accommodations.

The Supreme Court in its 1997 term clarified that the ADA prohibits discrimination in public accommodations against HIV-positive individuals. *Bragdon v. Abbott*, 524 U.S. 624, 141 L.Ed.2d 540, *on remand*, 163 F.3d 87 (1st Cir. 1998). The Court did so in the extremely important context of ensuring access by seropositive individuals to the medical services needed to combat HIV and AIDS and its disastrous effects. Petitioner's case concerns the next logical step in securing rights for persons disabled with HIV/AIDS: access to public services

that nurture physical and emotional health through exercise and recreation with other members of the community. Though a critical issue, it is one that has not been substantially addressed to date. A legal database search conducted by Petitioner's counsel of all federal district court and Circuit Court of Appeal cases addressing HIV discrimination failed to locate a published opinion on this specific issue. By granting *certiorari* in Petitioner's case, the Court has the opportunity to move proactively to establish the standards applicable to including HIV-positive persons in recreational facilities and programs for providers and claimants alike, as this issue is just beginning to be considered.

2. Ensuring access to recreational and athletic public accommodations is critical to the purpose and letter of the Americans With Disabilities Act to eradicate unfounded discrimination against HIV-positive individuals.

Access to public accommodations such as health clubs and recreational programs is critical to the physical and emotional well-being of of HIV-positive individuals. Acquired Immunodeficiency Syndrome ("AIDS") is the leading cause of illness-related mortality of young adults aged 25-44.[2] Because of the unique characteristics of the disease and the fear it engenders, persons with HIV/AIDS have been subjected to considerable social stigmatization and unreasonable and

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[2] *See Update: Trends in AIDS Incidence, Deaths and Prevalence -- United States, 1996*, 46 Morbidity and Mortality Weekly Report No. 8, 165, 171 (1997). Although AIDS has been repeatedly characterized as "invariably fatal" by courts, *e.g.*, *Chalk v. United States District Court*, 840 F.2d 701, 710 (9th Cir. 1988), this view is no longer universally accepted following recent reports on the efficacy of new treatments to moderate the extreme effects of HIV virus on the immune system. *See* discussion *infra*.

unfounded discrimination.[3] The American Medical Association has noted, "[a]n HIV-seropositive individual . . . may be subject to many and varied discriminations -- by family and loved ones, neighbors and friends, employers and fellow employees, and other providers and services."[4] Numerous federal and state courts have recognized this deeply-rooted stigma against HIV carriers.[5]

For these reasons, and because discrimination undermines public health efforts to limit the spread of the virus, the problem of discrimination against HIV-positive individuals

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[3] *See* Roger Steinbrook, M.D., *Battling HIV on Many Fronts*, 337 New England Journal of Medicine 11, 779-80 (1997) (the "prejudices, fears and legacy of discrimination associated with the [HIV] infection have deep roots in society").

[4] American Medical Association, Board of Trustees Report, *Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report*, 258 Journal of the American Medical Association No. 15, October 16, 1987 2097, 2098; *see also*, Steinbrook, *supra*.

[5] *See, e.g., Doe v. City of New York*, 15 F.3d 264, 267 (2d Cir. 1994) (noting that disclosure of HIV status could subject an individual to social ostracism and discrimination in employment, insurance and health care); *Severino v. North Fort Myers Fire Control Dist.*, 935 F.2d 1179, 1182, n. 4 (11th Cir. 1991) (finding that HIV-negative firefighter was "regarded as" handicapped and noting that the "contagiousness of the disease brings AIDS within the definition of handicap"); *Support Ministries v. Village of Waterford, N.Y.*, 808 F.Supp. 120, 132 (N.D.N.Y. 1992) (individuals with asymptomatic HIV were substantially limited in major life activities due to the prejudice and apprehension AIDS engenders on a social level); *Cain v. Hyatt*, 734 F.Supp. 671 (E.D.Pa. 1990) ("[t]he pervasive anxiety that AIDS is easily transmitted converges with and often ostensibly justifies the disapprobation of AIDS victims.").

was a particular concern to the drafters of the ADA.[6] The President's Commission on the HIV Epidemic stated in a report, the conclusions of which were adopted by Congress:

> [A]s long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care. This fear of potential discrimination . . . will undermine our efforts to contain the HIV epidemic and will leave HIV-infected individuals isolated and alone.

S. Rep. at 8; H. Rep. --2 at 31. Surgeon General C. Everett Koop testified before Congress, "[i]f counseling [about HIV prevention] and testing are to work most effectively, individuals must have confidence that they will be protected fully from HIV-related discrimination." *See* Americans With Disabilities Act of 1989; Hearings Before the Senate Comm. on Labor and Human Resources, 101st Cong. 367 (1989).

In order to prevent such discrimination from endangering the public health, Congress incorporated into the ADA a pre-existing definition of "disability" that applied to all persons with HIV. *See* S. Rep. at 22; H. Rep. --2 at 52; H. Rep. --3 at 28 n. 18. This Court recently confirmed that HIV-positive status may constitute a "disability" within the meaning of 42 U.S.C. § 12182 in *Bragdon*, 141 L.Ed.2d 540.

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[6] *See* S.Rep. No. 116, 101st Cong., 1st Sess. 8, 19 (1989) (herein "S.Rep."); H. Rep. No. 485, Part 2, 101st Cong., 2d Sess., 31, 48 (1990), reprinted in 1990 U.S.C.C.A.N. 303 (herein "H. Rep. --2"); H. Rep. No. 485, Part 3, 101st Cong., 2d Sess. 25 n. 7 (1990), reprinted in 1990 U.S.C.C.A.N. 445 (herein "H. Rep. --3").

a. HIV/AIDS Progression

The HIV virus is a remarkably complex retrovirus with a "profound pathogenicity," or ability to cause disease.[7] From onset, the virus targets and infects the host's "T cells" which activate and regulate the immune system's response.[8] The virus uses the T cells' own genes to manufacture new viruses that infect other cells, destroying increasing numbers of T cells in the process.[9] HIV targets those T cells which "may be the most essential in maintaining normal immune function," as well as cells which ingest pathogens and other harmful substances such as bacteria, viruses and dead tissue.[10] While a person who has tested HIV-positive may be outwardly asymptomatic for years after the first manifestations of infection, the virus continues to spread throughout the body.[11] An infected individual experiences a very high level of continuous "virologic mayhem," daily massive production of HIV virus, matched with massive destruction of T cells and generation of new cells attempting to

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[7] Warner C. Greene, *Molecular Insights Into HIV-1 Infection*, in The Medical Management of AIDS 17 (Merle A. Sande & Paul A. Volberding eds., 5th ed. 1997).

[8] Silvija I. Staprans & Mark T. Feinberg, *Natural History and Immunopathogenesis of HIV-1 Disease*, in The Medical Management of AIDS, *supra*, at 29. *See Bragdon*, *supra*, 141 L.Ed.2d at 554-555.

[9] Greene, *supra*; Staprans & Feinberg, *supra*, at 29; *Bragdon*, 141 L.Ed.2d at 555.

[10] Staprans & Feinberg, *supra*, at 29; *Bragdon*, 141 L.Ed.2d at 555.

[11] Sharon A. Riddler & John W. Mellors, *HIV-1 Viral Dynamics and Viral Load Measurement: Implications for Therapy*, in AIDS Clinical Review 1997/1998 47, 50 (Paul Volbedering & Mark A. Jacobson eds., 1998); *Bragdon*, 141 L.Ed.2d at 555-556.

replace them.[12] Even outwardly asymptomatic persons are at increased risk for numerous potentially serious diseases including mycobacterium tuberculosis, syphilis, acute and chronic hepatitis, toxoplasma condii, and pneumocystis carinii pneumonia.[13] In most persons infected with HIV, including Michael Montalvo, HIV progresses to severe immunodeficiency and AIDS.[14]

HIV patients are counseled to set their personal health as the first priority in their lives.[15] Patients are prescribed medications to slow the progression of the disease and prophylactic medications to prevent opportunistic infections.[16] In recent years, antiretroviral drugs called protease inhibitors and the the practice of "combination therapy" -- taking several antiretroviral drugs in combination -- have proven to be of great benefit in managing the symptoms of the disease and extending

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[12] Greene, *supra*, at 21; Riddler & Mellors, *supra*, at 49-50.

[13] Margaret A. Fischl, *An Introduction to the Clinical Spectrum of AIDS*, in Textbook of AIDS Medicine 149, 150 (Samuel Broder et al., eds., 1994); *Bragdon*, 141 L.Ed.2d at 556.

[14] Department of Health and Human Services, National Institutes of Health, *Report of the NIH Panel to Define Principles of Therapy of HIV Infection*, at 4 (1997).

[15] Lynda S. Doll & Beth A. Dillon, *Counseling Persons Seropositive for Human Immunodeficiency Virus Infection and Their Families*, in AIDS: Etiology, Diagnosis, Treatment and Prevention 533, 534-38 (Vincent T. DeVita et al. eds., 4th ed. 1997).

[16] Michael Clement & Harry Hollander, *Initial Evaluation of and Health Care Maintenance for the HIV-Infected Adult*, in The Medical Management of AIDS 130, 109 (Sande & Volberding, eds., 4th ed. 1995).

life expectancies.[17] These medications have enabled AIDS patients in developed countries to enter a new era of extended duration and quality of life.[18] Many children with HIV, like Michael Montalvo, are now surviving well into adolescence.[19]

In addition to physical health, the HIV virus threatens one's emotional health.[20] One medical commentator describes the impact of HIV thusly:

> All patients with HIV disease, regardless of physical health status, face fundamental questions regarding the quality and length of their lives. Specific stressors experienced by HIV-positive people may include prolonged periods of physical discomfort, disability, and dependence, lifestyle disruption, loss of work and reduced socioeconomic status, disruption of support networks including family supports, decreased self-esteem, and sustained periods of loss of personal

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[17] *See* Paul A. Volberding, *Protease Inhibitors Vindicated*, 350 Lancet SIII 10 (1997); 1997 *NIH Panel Report*, *supra*, at 7; Steven F. Decks & Paul A. Volberding, *HIV-1 Protease Inhibitors*, in AIDS Clinical Review 1997-1998 145, 174-75 (Paul A. Volberding & Mark A. Jacobson eds., 1998).

[18] Editorial, "HIV/AIDS in 1998 -- Gaining the Upper Hand?" 280 JAMA No. 1, at 87 (1998).

[19] *Disclosure of Illness Status to Children and Adolescents with HIV Infection*, *supra*, 103(1) Pediatrics 164-166 (1999).

[20] Doll & Dillon, *supra*, at 534.

autonomy.[21]

Most HIV patients fear that disclosure of their condition will result in stigmatization, rejection by family, friends and co-workers, and discrimination.[22] Stigma and discrimination are a significant source of depression and anxiety in many patients, as is others' fear of infection, even through casual contact.[23]

b. HIV/AIDS Transmission

The vehicles of HIV transmission have been well established since the mid-1980s: blood and blood products, semen, cervical and vaginal secretions, and breast milk.[24] According to the Centers for Disease Control and Prevention, there have been no documented cases of transmission of HIV through physical contact in athletics in the nearly twenty-year history of the disease.[25] In the health care setting, in which

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[21] Lisa Capaldini, *HIV Disease: Psychosocial Issues and Psychiatric Complications*, in The Medical Management of AIDS, *supra*, at 289, 296 (4th ed.).

[22] Doll & Dillon, *supra*, at 535.

[23] Doll & Dillon, *supra*, at 535.

[24] Staprans & Feinberg, *supra*, at 29; John Barlett, Medical Management of HIV Infection, no. 2, at 2-3, 9-11 (1997).

[25] CDC, *HIV/AIDS Prevention Update*, http://www.cdc.gov/nchstp/hiv_aids/pubs/faq/faq30.htm (last updated November 30, 1998). *See also*, Mast, et al., *Transmission of Blood-Borne Pathogens during Sports: Risk and Prevention*, 122 Annals of Internal Medicine 283 (1995) (Commenting, "Only one instance of HIV infection thought to be related to sports has been reported in the medical literature; this infection was diagnosed in a recreational soccer player in Italy. However, public health officials in Italy who reviewed the available data could not satisfactorily rule out nonathletic risk factors for

much of the study of the transmission of HIV has taken place, the primary risk of transmission from a patient to a health care worker arises from percutaneous exposure, such as a needlestick or a cut with a sharp object.[26] This is because such an incident exposes the worker to a potential invasion of the virus into the worker's own blood stream resulting in delivery of a higher viral load into the hemitic system. However, even in such unlikely circumstances, the risk of actual transmission to infected blood following percutaneous exposure is only .3%, or one transmission for every 333 exposures.[27] Likewise, no case of HIV transmission by exposure to aerosolized (airborne in water vapor) HIV particles in the context of dental treatment has ever been documented, and the possibility of such transmission in the occupational setting has been called merely "theoretical."[28]

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this man, who had been working in a drug-dependency rehabiliation center, nor could they definitively establish athletic activity as the source of infection," and concluding, "a study of on-the-field bleeding injuries during professional football competitions in the United States concludes that the potential risk for HIV transmission to each player is extremely low (less than 1 per 85 million game contacts)."

[26] See generally, David M. Bell, *Human Immunodeficiency Virus Transmission in Health Care Settings: Risk and Risk Reduction*, 91 Am.J.Med. 3B-294S (1991 Supp. 3B).

[27] *Id.*

[28] Ruthanne Marcus & David M. Bell, *Occupational Risk of Human Immunodeficiency Virus Infection in Health Care Workers*, in AIDS: Etiology, Diagnosis, Treatment and Prevention 645, 651 (Vincent T. DeVita, Jr., et al. eds., 4th ed. 1997).; David M. Bell, *Human Immunodeficiency Virus*, *supra*, at 3B-298S ("There are no known instances of transmission of a blood-borne pathogen by aerosol in a clinical setting."). *See also Bragdon v. Abbott*, 141 L.Ed.2d at 567 ("Petitioner's expert witness conceded . . . that no evidence suggested the spray could transmit HIV. His opinion on airborne risk

B. The Fourth Circuit's Decision is at Odds With the Pronouncements of this Court and Other Circuits Regarding the Requisite Standard of Proof to Establish Whether a Disabled Person Posed a "Direct Threat" to Others.

1. Respondent unilaterally excluded Petitioner despite the medical opinion of Petitioner's treating physician that he posed no danger to himself or others, and without countervailing objective medical evidence to the contrary, in derogation of the standards established by this Court in *School Board of Nassau County v. Arline* and *Bragdon v. Abbott*.

Abbott v. Bragdon involved a medically sophisticated provider of public services, a licensed dentist. This Court nonetheless instructed that Dr. Bragdon could not rely on his own opinion in refusing to treat an HIV-infected individual in his office; instead, he had a "duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession." 141 L.Ed.2d at 564. "His belief that a significant risk existed, even if maintained in good faith, would not relieve him from liability." *Id.*

Petitioner's case presents the situation of a non-medically sophisticated provider of recreational accommodations who, far from obtaining an objective medical opinion that Petitioner's inclusion posed a "significant risk" to others, actually determined to exclude him despite having a qualified medical opinion to the contrary. When Respondent

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was based on the absence of contrary evidence, not on positive data.")

challenged Petitioner's fitness to participate, Mr. Montalvo provided an affidavit from Michael's treating physician, Dr. Suzanne R. Lavoie, an expert in pediatric AIDS. The affidavit stated:

> I am a medical doctor duly licensed and practicing in the State of Virginia. I am a treating physician for Michael Montalvo and I am thoroughly familiar with his physical condition. I have recently examined Michael Montalvo and find him fit to begin karate classes.

App. at 77. At trial, Dr. Lavoie discussed her conclusions:

> As a physician working in infectious diseases with patients with Acquired Immunodeficiency Syndrome we consider the known causes of transmission of that virus when people request information about participation. Based on the known ways of transmission of this virus I felt that participation in karate would not pose a risk either to Michael or to other people in the class.

App. at 74. In spite of this opinion by Petitioner's treating physician, Respondent chose to rely on his own personal beliefs and exclude Petitioner. *Bragdon* stands for the principle that access to public accommodations must not depend on the unschooled and arbitrary perceptions of providers; rather, a decision to exclude an individual with an infectious disease must be made on the basis of objective medical advice. If uncorrected, the Fourth Circuit's decision may well be taken as a signal to providers of public accommodations that they may arbitrarily exclude handicapped individuals without the benefit of the professional guidance mandated by the ADA.

2. The district court improperly refused to permit any quantified assessment by testifying medical experts of the level of risk of transmission of HIV to the instructors and students in U.S.A. Bushidokan, instead improperly relying upon unquantified speculation about the possibility of transmission, in derogation of the standards established by this Court in *School Board of Nassau County v. Arline* and *Bragdon v. Abbott*, and analogous decisions of other federal circuits under the ADA.

In codifying the "direct threat" defense into the ADA, Congress expressly adopted the objective test enunciated in *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987) to determine whether discrimination is justified by a "direct threat" defense. The *Arline* Court emphasized that in making this objective determination of threat, "courts normally should defer to the reasonable medical judgments of public health officials." 480 U.S. at 286 n. 15, 288; *Bragdon*, 141 L.Ed.2d at 564. *Arline* states:

> [T]he district court will need to conduct an individualized inquiry and make appropriate findings of fact. * * * * In the context of the employment of a person handicapped with a contagious disease, . . . this inquiry should include [findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to the parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

Id. at 287-88. The Court required this objective, fact-specific inquiry because the "direct threat" test aims to "protect[] handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns . . . as avoiding exposing others to significant health and safety risks." 480 U.S. at 287. Pursuant to *Arline*, the enacting regulations of the ADA required a finding of "direct threat" to be "based on reasonable judgment that relies on current medical knowledge or on the "best available objective evidence . . . " 28 C.F.R. § 36.208(c)(1997). "Sources for medical knowledge include guidance from public health authorities, such as the U.S. Public Health Service, the Centers for Disease Control, and the National Institutes of Health, including the National Institute of Mental Health." *Id.* at App. B, § 36.208(c). *See Bragdon*, 141 L.Ed.2d at 565. Apart from the Fourth Circuit, the Circuit Courts of Appeal have complied with the ADA's directive in assessing the risk of HIV transmission in public accommodations. *E.g., American Dental Ass'n v. Martin*, 984 F.2d 823, 828 (7th Cir. 1992) ("judgments of the [United States Centers for Disease Control and Prevention] are entitled to respect"), *cert. denied*, 510 U.S. 859 (1993); *id.* at 832 (Coffey, J., concurring)(the CDC is medically and scientifically qualified to determine and evaluate if there is in fact a significant risk in the health care arena); *Chalk v. United States District Court*, 840 F.2d 701, 706-708 (9th Cir. 1988) (noting that *Arline* "admonishes" courts to defer to public health officials and crediting the position of the CDC, Surgeon General and American Medical Association).

Interpreting the *Arline* objectivity requirement in the context of HIV and AIDS, the Supreme Court in *Bragdon* placed particular stress on the necessity for medical evidence pertaining not just to a theoretical presence of risk, but to a quantification of the risk based upon the best science available.

"Because few, if any, activities in life are risk free, *Arline and the ADA do not ask whether a risk exists, but whether it is significant.*" 141 L.Ed.2d at 564 [emphasis added], citing *Arline*, 480 U.S. at 287, and 42 U.S.C. § 12182(b)(3). Reviewing the evidence adduced in the lower courts, the Supreme Court questioned the First Circuit's reliance on 1993 CDC Dentistry Guidelines and the 1991 American Dental Association [ADA] Policy on HIV on the ground that the policies were inconclusive because "[t]hey do not assess the level of risk." 141 L.Ed. 2d at 566. The Court stated that "[e]fforts to clarify dentists' ethical obligations and to encourage dentists to treat patients with HIV infection with compassion may be commendable, but *the question under the statute is one of statistical likelihood*, not professional responsibility." *Id.* (Emphasis added.)

Contrary to the Supreme Court's directive and the rule followed in other circuits that have addressed the issue, the District Court below failed to engage in an assessment of the level of risk accompanying inclusion of Petitioner in Respondent's school. The court repeatedly ordered Petitioner's testifying expert not to attempt to quantify or assess the level of risk involved:

> Q [By Petitioner's Counsel] Do you have any medical judgment concerning a probability or percentage of risk factor of Michael if he were bleeding and the possibility that another individual would contract the HIV virus from Michael, an if so, tell Judge Williams what that opinion is?
>
> MR. COLLIER: Your Honor, I'm going to object at this point. I'm not sure that's a proper hypothetical. Under what circumstance --

> THE COURT: There are so many variables that an answer to this question wouldn't be very probative, would it? Suppose he has an open wound excreting blood and the person that he's grappling with has an open wound and their blood gets mixed, I take it that would be a means of transmission?
>
> THE WITNESS: Potentially.
>
> THE COURT: There are so many variables that any answer would not be probative of anything.
>
> * * * *
>
> Q [By Petitioner's Counsel] Dr. Lavoie, in your medical judgment if universal precautions are practiced in a contact sport, what is the risk of transmittal of infection from an HIV positive person to a non-HIV positive person?
>
> MR. COLLIER: Your Honor, again I'm going to object.
>
> THE COURT: And again I'll sustain the objection because there are so many variables that any answer would be basically meaningless.

App. at 81 - 82, 84. Dr. Lavoie was permitted to testify, however, that she was aware of no anecdotal or documented cases of transmission from the open wound of one person into the open wound of another, a fact the court failed to rely upon. App. at 82.

Further, the principle evidence relied on by the Court for its determination that Michael Montalvo posed a "direct threat" to others was the poorly founded opinion of Dr. Carey Bruce Savitch. In his deposition, which was introduced at trial in lieu of live testimony, Savitch testified:

> Q. Can the HIV virus be transmitted by introducing the blood of one person, who is HIV positive, into a wound of another person?
> A. There is no question in my mind that it can.
> Q. Okay. And would you describe with some technical precision, the percentages that are involved in that sort of environment?
> A. That is a good question. *Nobody knows the exact percentage*, because you could never do a study. You would never have somebody with open wounds and then splash blood into that wound and try to determine how often a person would become infected that way.

App. at 105(emphasis added). Savitch disingenuously sidestepped the analysis mandated by this Court in *Bragdon*. The "exact percentage" is not the requisite inquiry, but some objective "assessment[ment of] the *level* of risk." *Bragdon*, 141 L.Ed.2d at 566 [emphasis added]. The Fourth Circuit's reliance on this type of speculative testimony flies in the face of the objective medical inquiry sought by the *Arline/Bragdon* standard, and places it at odds with the other Circuit Courts that have rejected reliance on speculative testimony.

Another significant portion of Dr. Savitch's testimony on which the court relied was his assertion that a blood splash on intact skin could result in an HIV infection. App. at 40, 121. However, nothing in Savitch's deposition testimony supported this naked assertion. On cross examination, Dr. Savitch could not provide a medical source or cite authority for his assertion that HIV may be transmitted through a blood splash other than an undocumented recollection. App. at 134-35.

With the notable exception of the Fourth Circuit in the instant case, the federal courts after *Arline*, have sought to

guard against unfounded speculation (posing as "expert opinion") of whether the risk of transmission of HIV or AIDS amounts to a "direct threat" under the ADA. For example, in *Abbott v. Bragdon*, 107 F.3d 934, 943 (1st Cir. 1997), the First Circuit observed:

> Generalities about health-care workers aside, [the dentist, defendant] does not cite a single confirmed instance of HIV transmission to a dentist. He does, of course, point to seven instances of "possible transmissions" of HIV to dental workers, *but mere possibilities are too speculative to satisfy a litigant's burden of production* at the summary judgment stage.

107 F.3d at 946 (emphasis added). In *Chalk v. United States Dist. Court for the Central Dist. of California*, the plaintiff, a teacher of hearing-impaired students, was diagnosed with AIDS after a bout with pneumocystis carinii pneumonia. 840 F.2d at 703. Upon his recovery and return to work, Chalk's employer reassigned him to an administrative position and barred him from teaching in the classroom, in spite of the opinion of the Director of Epidemiology and Disease Control for the Orange County Health Care Agency that "[n]othing in his role as a teacher should place his students or others in the school at any risk of acquiring HIV infection." *Id.* The district court declined to require the school district to reinstate Chalk in his teaching position, but the Ninth Circuit reversed. 840 F.2d at 709. The court weighed the evidence adduced by the plaintiff, noting that "[n]one of the identified cases of AIDS in the United States are known or are suspected to have been transmitted

from one child to another in school, day care or foster care settings." 840 F.2d at 706.[29]

Like the District Court in Petitioner's case, the trial court in *Chalk* weighed the *Arline* factors and placed particular emphasis on the "catastrophic" nature of the risk of contracting AIDS and the absence, in its view, of sufficient medical data to make a definite determination of the extent of the risk:

> Now, here, according to present knowledge, the risk probably is not great because of the limited ways that medical science believes the disease is transmitted. But, of course, if it is transmitted the result is horrendous. It seems to me the problem is that we simply do not know enough about AIDS to be completely certain. The plaintiff has submitted massive documentation tending to show a minimal risk * * * * But I think it's too early to draw a definite conclusion, as far as this case is concerned, about the extent of the risk.

Id. In denying the injunction on this basis, the Ninth Circuit held that "the district court failed to follow the legal standards set forth in *Arline* and improperly placed an impossible burden of proof on the petitioner." *Id.* The district court erred by "improperly rel[ying] on speculation for which there was no credible support in the record." 840 F.2d at 708.

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[29] The Ninth Circuit also credited the position of its *amicus* the American Medical Association ("AMA"), which "summarized the medical evidence and concluded that 'there is no evidence in the relevant medical literature that demonstrates any appreciable risk of transmitting the AIDS virus under the circumstances likely to occur in the ordinary school setting.'" 840 F.2d at 707, quoting Amicus Brief of the AMA at 28.

The Ninth Circuit also relied upon decisions by other federal and state courts rejecting a speculative approach to the risk of transmission of disease, notably *Thomas v. Atascadero United School Dist.*, 662 F.Supp. 376 (C.D.Cal. 1987). *Chalk*, 840 F.2d at 708. *Thomas* granted a preliminary injunction prohibiting a school district from excluding a child with AIDS from the classroom, despite the child's involvement in a biting incident. The court found that:

> The overwhelming weight of medical evidence is that the AIDS virus is not transmitted by human bites, *even bites that break the skin.* * * * * Any theoretical risk of transmission of the AIDS virus by Ryan in connection with his attendance in regular kindergarten class is so remote that it cannot form the basis for any exclusionary action by the School District.

662 F.Supp. at 380 [emphasis supplied] Considering this and other cases,[30] the Ninth Circuit concluded in *Chalk*:

> To allow the court to base its decision on the fear and apprehension of others would frustrate the goals of section 504. "[T]he basic purpose of Section 504 [is] to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or ignorance of others." *Arline*, 107 S. Ct. at 1129. The

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[30] *See also, Ray v. School Dist. of DeSoto County*, 666 F.Supp. 1524, 1535 (M.D. Fla. 1987) (prohibiting school district from excluding three seropositive brothers from the classroom and rejecting the "future theoretical harm" of transmission of AIDS in the classroom); *District 27 Community School Board v. Board of Educ.*, 130 Misc.2d 398, 502 N.Y.S.2d 325, 335-37 (Sup.Ct. 1986) (upholding board's policy of admitting students with AIDS into the classroom on a case-by-case basis on the ground that transmission of the AIDS virus in the classroom setting was "a mere theoretical possibility").

> Supreme Court . . . [in *Arline*] rejected the argument that exclusion could be justified on the basis of "pernicious mythologies" or "irrational fear." *Id.* at 1129-30 & n.12.

Chalk, 840 F.2d at 711.

Similarly, the Eleventh Circuit ruled in *Doe v. DeKalb County*, 145 F.3d 1441 (11th Cir. 1998), that the district court had improperly found only a remote, theoretical risk of transmission of HIV via blood-to-blood contact between a teacher and his sometimes-violent, emotionally handicapped students. 145 F.3d 1446. The district court erred by failing to make specific factual findings with respect to the *Arline* factors that explained why it felt the risk was "remote." *Id.*

By failing to require an objective, quantified assessment of the level of the risk of transmission of HIV by the inclusion of Petitioner in Respondent's karate school, as required by the Supreme Court in *Arline* and *Bragdon*, the Fourth Circuit has set itself in conflict with this Court and the other circuits that have addressed the issue. *Certiorari* is appropriate to correct the Fourth Circuit and to bring the circuits into conformity on this important question.

3. The Court of Appeals improperly held that Respondent's offer of isolation of Petitioner via a one-on-one instructional program was a "reasonable accommodation" of his disability.

The ADA defines "discrimination: under the Act to include "subject[ing] an individual . . . on the basis of a disability or disabilities . . . to a denial of the opportunity . . . to participate in or benefit from the goods, services, facilities,

privileges, advantages, or accommodations of an entity." 42 U.S.C. § 12182(b)(1)(A)(i). Affording participation on an unequal or separate basis to other participations in the program is also prohibited. 42 U.S.C. § 12182(b)(1)(A)(ii)-(iii). Further, "accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual." 42 U.S.C. § 12182(b)(1(B).

Although the statutory burden of accommodating a disability is on the place of accommodation, Respondent offered not an "accommodation," but isolation of Michael away from the other children, and no benefit but an unequal benefit. The record does not reflect that any reasonable alternative was considered, such as permitting Michael to participate with the other children in instructional periods or conducting his sparring training with the staff in the presence of the other children.

The ADA was intended to strike at the increasing isolation of HIV-positive individuals based on unreasonable fear and apprehension of transmission. In fact, the problem of HIV-positive children being barred from schools was common in the 1980's, and formed the basis for many of the early decisions holding that HIV status constituted a "disability" under the ADA.[31] Day care centers and schools still turn away HIV-positive children out of fear and ignorance.[32]

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[31] *See, e.g., Ray v. DeSoto County*, 666 F.Supp. 1524; *Thomas v. Atascadero*,861 F.2d 1502; *Martinez v. School Board of Hillsborough County*, 861 F.2d 1502 (11th Cir. 1988); *Doe v. Dolton Elementary School Dist. No. 148*, 694 F. Supp. 440 (N.D. Ill. 1988).

[32] *United States v. Happy Time Day Care Center*, 6 F. Supp. 2d 1073 (W.Dist. Wisc. 1998). *See also* "Schools Say Child With HIV Denied Admission to Day Care Centers," *Disability Compliance Bulletin* 11 (July

Discrimination against and isolation of children in the name of "accommodation" has been particularly prevalent in the HIV context. For example, a family in Florida with HIV-infected children received death threats, and their home was burned in an attempt to keep the children from attending school.[33] An infected child was sprayed with bleach after sneezing in her kindergarten classroom.[34] HIV-status discrimination is particularly telling on children, who are perhaps most profoundly affected by the terminal nature of the disease.[35] Thus, while most children are continually planning for their future -- what sports to play, which schools to attend, where to live and work, what friends to seek out -- HIV-positive children are hobbled by a strict regimen of medical treatment and by the knowledge that, unless a cure is found quickly, they will almost certainly not grow into adulthood, complete their schooling, have a career, or have children and grandchildren. Their ability to plan, to play, to go to school, to form intimate relationships,

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31, 1997); Jonathon Briggs, "Parents Find Support They Can Depend On," *Arizona Republic*, Sept. 8, 1996, at F10 (HIV-positive women and children face problems obtaining child care).

[33] *See* Elizabeth Glaser & Laura Palmer, In the Absence of Angels, 59-60 (1991).

[34] *See I Need a Friend: Kids Talk About Having the AIDS Virus* (National Cancer Institute, Pediatric Branch) (videotape on file with the Elizabeth Glaser Pediatric AIDS Foundation).

[35] *Disclosure of Illness Status to Children and Adolescents with HIV Infection, supra.*

travel and live the life of a normal child and adolescent is restricted, then altogether eliminated by the disease.[36]

II. THIS CASE IS APPROPRIATE FOR REVIEW BY A GRANT OF CERTIORARI, VACATION AND REMAND IN LIGHT OF THIS COURT'S DECISION IN *BRAGDON V. ABBOTT.*

Petitioner submits that his case raises important issues that deserve a substantial review by the Court on the merits. However, if the Court does not elect to grant *certiorari* on this basis, Petitioner respectfully suggests that the case is appropriate for disposition by a grant of *certiorari*, vacation and remand (herein "GVR") in light of this Court's recent decision in *Bragdon v. Abbott*, 141 L.Ed.2d 540, insofar as the lower court rulings cannot withstand scrutiny under the standards enunciated in that decision.

As noted, the District Court relied on *School Board of Nassau County v. Arline* to support its conclusion that Petitioner's HIV status precluded accommodation under the

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[36] In the words of HIV-afflicted children:

> I often wonder how much longer in life I have. Sometimes I think I only have months to live. Other times I'm more hopeful, and I think I'll live at least a couple more years.
>
> [I]f I didn't have AIDS . . . I would not have to get up at 11 pm or at 7 am to take medicine.
>
> Being normal is not worrying every day about if and when you will get sick and about how people will treat you at that time. I would do anything so that I could be normal.

Be a Friend: Children Who Live With HIV Speak (Lori S. Weiner et al. eds., 1994), at 11, 13, 18.

ADA. The court, however, did not have the benefit of the Supreme Court's opinion in *Bragdon* for guidance on the "direct threat" standard in the context of HIV/AIDS, which was issued on June 25, 1998. While Petitioner's Opening Brief before the Fourth Circuit, filed April 14, 1998, also was not able to discuss the application of *Bragdon*, the opinion was brought to the panel's attention during oral argument on October 26, 1998. App. at A18, A29. Nonetheless, the Fourth Circuit's decision makes only passing references to *Bragdon*, failing to substantively address in any meaningful fashion the guidance provided by the Supreme Court in that case. App. at A8 - 9.

This Court's power to GVR in light of an intervening decision of this Court is well-established:

> [T]he GVR order has, over the past 50 years, become an integral part of this Court's practice, accepted and employed by all sitting and recent judges. We have GVR'd in light of a wide range of developments, including our own decisions.....

Lawrence v. Chater, 516 U.S. 163, 166-67 (1996). As the Court has explained:

> In an appropriate case, a GVR order conserves the scarce resources of this Court that might otherwise be expended on plenary consideration, assists the court below by flagging a particular issue that it does not appear to have fully considered, assists this Court by procuring the lower court's insight before we rule on the merits, and alleviates the potential for unequal treatment that is inherent in our inability to grant plenary review of all pending cases raising similar issues....."

Id. at 167. For this reason, where "intervening developments, or recent developments that we have reason to believe the court below did not fully consider, reveal a reasonable probability that the decision below rests on a premise that the lower court would reject if given the opportunity for further consideration...a GVR order is, we believe, potentially appropriate." *Id.* at 167.

The GVR standards are certainly applicable to a case such as this, which arises in a nascent area of the law that deserves closer scrutiny. As the Court itself noted in *Bragdon*:

> When attention has been focused on other issues, or when the court from which a case comes has expressed no views on a controlling question, it may be appropriate to remand the case rather than deal with the merits of that question in this Court. This consideration carries particular force where, as here, full briefing directed at the issue would help place a complex factual record in proper perspective. Resolution of the issue will be of importance to health care workers not just for the result but also for the precision and comprehensiveness of the reasons given for the decision.

141 L.Ed.2d at 567-68 (internal quotation marks and citation omitted). Petitioner submits that, like the important issue of provision of medical services to HIV-positive members of the community, the critical issue of inclusion of seropositive members in recreational and athletic places of accommodation -- institutions that, with schools, churches and other institutions, create community itself and foster health and quality of life -- deserves thoughtful consideration under the guidance of this Court's established standards.

CONCLUSION

Petitioner respectfully submits that by permitting Respondent's decision to exclude Petitioner to be made without the benefit of objective medical opinion, then justified *ex post facto* by medical testimony that completely failed to objectively assess the level of risk, the Fourth Circuit's decision failed to adhere to both the spirit and the letter of the public accommodations provisions of Title III of the ADA.

For the reasons set forth above, Petitioner prays that his Petition for Writ of Certiorari be granted and that this Honorable Court decide the issues raised in the Petition, or in the alternative, that the Court vacate the judgment of the Fourth Circuit and remand the case to the District Court for further proceedings not inconsistent with the standards enunciated in *Bragdon v. Abbott*.

Respectfully submitted,

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May 12, 1999

APPENDIX
TO PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

TABLE OF CONTENTS

Page(s)

1. Opinion of the United States Court of Appeals for the Fourth Circuit in *Montalvo v. Radcliffe, et al.*, Appeal No. 98-1169 (February 12, 1999) A1-A15

2. Transcript of Oral Argument before the United States Court of Appeals for the Fourth Circuit on October 26, 1998 . . . . . A16-A32

3. Final Order and Findings of Fact and Conclusions of Law in *Montalvo v. Radcliffe, et al.*, United States District Court for the Eastern District of Virginia, Case No. 3:97CV487, entered January 29, 1998 . . . . . A33-A49

4. Text of Americans With Disabilities Act, 42 U.S.C. § 12181, 12182 (1999) A50-A58

5. Docket in *Montalvo v. Radcliffe, et al.*, United States District Court for the Eastern District of Virginia, Case No. 3:97CV487, as of February 17, 1998 . . . . . A59-A65

6. Amended Complaint Filed June 27, 1997 . . . A66-A73

7. Stipulations of Fact filed January 16, 1998 . A74-A76

8. Exhibit 2 to the Joint Appendix in the Fourth Circuit Court of Appeals, Affidavit of Suzanne R. Lavoie A77

9. Excerpts from Transcript of Bench Trial held before the Honorable Richard L. Williams on January 22, 1998, Testimony of Suzanne R. Lavoie, M.D. A78-A91

10. Excerpts from Transcript of Bench Trial held before the Honorable Richard L. Williams on January 22, 1998, Testimony of Luciano Montalvo A92-A99

11. Excerpts of Transcript of Deposition of Carey Bruce Savitch filed January 22, 1998, Joint Appendix in the Fourth Circuit Court of Appeals, pp. 98 et seq. A100-A146

LUCIANO MONTALVO, individually and as the parent and guardian of Michael Montalvo, Plaintiff-Appellant,
v.
JAMES P. RADCLIFFE, II; SOUTHSIDE VIRGINIA POLICE KARATE ASSOCIATION, INCORPORATED, d/b/a U.S.A. Bushidokan,
Defendants-Appellees, and DONNA RADCLIFFE,
Defendant.

No. 98-1169

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

167 F.3d 873

February 12, 1999, Decided

COUNSEL:
ARGUED:
Terry William Raney, Richmond, Virginia, for Appellant.

Nathaniel Macon Collier, III, Colonial Heights, Virginia, for Appellees.

ON BRIEF: John W. Whitehead, Stephen H. Aden, THE RUTHERFORD INSTITUTE, Charlottesville, Virginia, for Appellant.

JUDGES: Before WILKINS and NIEMEYER, Circuit Judges, and BLAKE, United States District Judge for the District of Maryland, sitting by designation. Judge Niemeyer wrote the opinion, in which Judge Wilkins and Judge Blake joined.

OPINION BY: NIEMEYER

OPINION: OPINION

NIEMEYER, Circuit Judge:

Michael Montalvo, a 12-year old boy with AIDS, was denied admission to a traditional Japanese style martial arts school because of his HIV-positive status. In this action, brought under Title III of the Americans with Disabilities Act (prohibiting discrimination on the basis of disability by places of public accommodation), the district court denied Montalvo relief because his condition posed a significant risk to the health or safety of other students and no reasonable modification could sufficiently reduce this risk without fundamentally altering the nature of the program. We affirm.

I.

Southside Virginia Police Karate Association, Inc. operates a karate school in Colonial Heights, Virginia, known as U.S.A. Bushidokan, which is owned by James P. Radcliffe, II. The school teaches exclusively traditional Japanese, combat-oriented martial arts rather than the more prevalent, family-oriented fitness programs offered by most martial arts schools. Within the first three weeks of lessons at U.S.A. Bushidokan, students learn techniques that involve substantial body contact, and within the first few months they apply these techniques to spar in actual combat situations. Radcliffe testified at trial that the sparring often results in injuries which, while minor, are bloody:

> In the course of their sparring or their fighting a blow can take place that may initiate some type of open wound or may initiate blood flow. The continuation of

> their activity, it continues for as long as they continue to show defensive techniques and then at some point, maybe seconds, maybe even closer up to a minute, they will break and at that point that's normally the point where we'll notice that someone has blood on them.
>
> When we spar one person off another, at the finish of that whole thing, 10 to 15 minutes, we'll have blood all over our uniforms and hands and have no idea where it came from, who it came from or things of that nature.

He explained that to progress "through the belt," a level of achievement, a student must "engage in combat activity fighting. You have to do the self-defense. It involves contact, that's what we do." Radcliffe noted that inherent in this form of karate are "consistently scratched skin, scratches, gouges, bloody lips, bloody noses, things of that nature."

In May 1997, Luciano and Judith Montalvo applied to enter their 12-year old son, Michael, into group karate classes at U.S.A. Bushidokan because Michael wanted to learn karate with some friends who had already begun lessons there. Luciano Montalvo signed a "Membership Application and Agreement" form in which he warranted that Michael was "in good health and that [he] suffer[ed] from no illness or condition . . . which would possibly be infectious to others" and that the Montalvos understood that "no member [would] use the facilities with any open cuts, abrasions, open sores, infections, [or] maladies with the potential of harm to others." In fact, however, Michael had AIDS. The Montalvos did not disclose that fact to U.S.A. Bushidokan because they were afraid that U.S.A. Bushidokan would not enroll Michael if it knew of his HIV-positive status.

Later, on the same day that the Montalvos submitted Michael's application, Radcliffe, having received information from an anonymous source, telephoned the Montalvos to inquire whether Michael had AIDS. Luciano Montalvo demanded to know the source of the information and adamantly and repeatedly denied that Michael had AIDS or was HIV-positive. After the Montalvos gave U.S.A. Bushidokan an affidavit from Michael's treating physician, Dr. Suzanne R. Lavoie, stating her medical opinion that Michael was "fit to begin karate classes," Michael began participating in karate classes at U.S.A. Bushidokan. After the first class, however, Radcliffe telephoned Luciano Montalvo to tell him that Dr. Lavoie's letter "wasn't sufficient" and to request that Michael have an AIDS test. This request prompted Luciano Montalvo to admit finally that Michael had AIDS.

Radcliffe then met with the Montalvos and informed them that Michael would not be allowed to participate in group karate classes at U.S.A. Bushidokan because of the risk of transmitting HIV to other students through frequent bloody injuries and physical contact. Radcliffe, however, did offer to give Michael private karate lessons. Luciano Montalvo immediately rejected that proposal because "the whole reason" he signed Michael up for lessons was that Michael "wanted to be with his friends."

On behalf of Michael, Luciano Montalvo filed this action against U.S.A. Bushidokan and Radcliffe under the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq., and the Virginia Persons with Disabilities Act, Va. Code § 51.5-44B, requesting an injunction requiring the defendants to give Michael access to and the benefit of the group martial arts classes and to refrain from discriminating against Michael in any manner because he had AIDS. The Montalvos also sought damages and the costs of litigation.

Following a bench trial, the district court ruled in favor of U.S.A. Bushidokan, n1 concluding that:

> Placing plaintiff directly into the martial arts classes at U.S.A. Bushidokan would present a direct threat to the health and safety of the instruction personnel and the students in violation of 42 U.S.C. § 12182[(b)](3). Forcing U.S.A. Bushidokan to alter the format of its instruction towards a "softer," less-rigorous style would be equally hazardous; it would eliminate the function of the training at U.S.A. Bushidokan and comprise an unreasonable modification in violation of 42 U.S.C. § 12182(b)(2) and well established case law. Finally, in light of the rigor and intensity of training at U.S.A. Bushidokan, defendant's offer to provide plaintiff with private lessons in lieu of class instruction is a "reasonable" accommodation under § 12182(b)(2).

The court rejected the state law claims for the same reasons it rejected the claims under the Americans with Disabilities Act.

n1 Because the karate school was owned and operated by U.S.A. Bushidokan and the Montalvos' contract was with the corporation, the district court dismissed Radcliffe as a defendant, a ruling that the Montalvos have not challenged on appeal.

In making its ruling, the district court found as facts, *inter alia*, that U.S.A. Bushidokan taught "hard-style Japanese karate . . . with a heavy emphasis on sparring and actual-fight simulation"; that there was "a high frequency of minor but bloody abrasions among the students"; and that the blood from such injuries was "extremely likely" to spill onto the students' hands, uniform, mouth, or "even onto the students with whom

he or she is training." The court found that it was "impossible" for U.S.A. Bushidokan to detect and attend to each injury immediately despite "conscientious and effective treatment procedures." The court acknowledged the existence of "universal precautions" -- established procedures for handling blood safely -- but found that even "a strict adherence" to such precautions would not prevent the spillage of blood and other bodily fluids and the attendant risk of HIV transmission. Based on the expert testimony offered by both sides, the court found that HIV can be transmitted by "introducing the blood of one person who is HIV-positive into a wound of another person," or even "when contaminated blood is splashed into the eyes or onto the skin, even in the absence of an open wound." The court found that the transmission risk if Michael were to participate in group classes at U.S.A. Bushidokan would be "significant."

From the district court's judgment in favor of U.S.A. Bushidokan and Radcliffe, the Montalvos filed this appeal. On appeal, they argue that they established their case for discrimination under the Americans with Disabilities Act based on Michael's exclusion from karate classes because of his having AIDS and that the district court clearly erred in finding (1) that "Michael's condition posed a 'direct threat' to the health and safety of other class members" and (2) that "U.S.A. Bushidokan's offer of private lessons to Michael was a reasonable accommodation [for] Michael's disability." n2

n2 Title III of the Americans with Disabilities Act does not impose a requirement that a place of public accommodation provide a "reasonable accommodation" for a disability, but rather that, in limited circumstances, it make reasonable modifications. *See* 42 U.S.C. §§ 12182(b)(2)(A)(ii), 12182(b)(3).

II.

Title III of the Americans with Disabilities Act ("ADA") was enacted to facilitate disabled individuals' access to places of public accommodation. Consistent with this goal, the Act states broadly:

> No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

42 U.S.C. § 12182(a). The ADA defines "denial of participation" in a program offered by a place of public accommodation to be an act of discrimination. 42 U.S.C. § 12182(b)(1)(A)(i).

Recognizing that the need to protect public health may at times outweigh the rights of disabled individuals, Congress created a narrow exception to this broad prohibition against discrimination based on disability in places of public accommodation. Thus, a place of public accommodation is entitled to exclude a disabled individual from participating in its program "where such individual poses a direct threat to the health or safety of others." 42 U.S.C. § 12182(b)(3) (emphasis added). The Act defines "direct threat" as "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." *Id.*

When determining whether an individual poses a "direct

threat," a place of public accommodation must not base its calculus on stereotypes or generalizations about the effects of a disability but rather must make "an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence." 28 C.F.R. § 36.208(c). The relevant factors which the place of public accommodation must weigh and balance are "the nature, duration, and severity of the risk and the probability that the potential injury will actually occur." Id.; see also 28 C.F.R. Pt. 36, App. B, p. 598 (1998) (noting that the direct threat provision in Title III of the ADA codifies *School Bd. of Nassau County v. Arline*, 480 U.S. 273, 287-88, 94 L. Ed. 2d 307, 107 S. Ct. 1123 (1987) (delineating criteria for determining whether, under § 504 of the Rehabilitation Act, a tubercular teacher posed a significant risk to the school community)).

If the place of public accommodation determines that the individual would pose a significant risk to the health and safety of others, it must then ascertain "whether reasonable modifications of policies, practices, or procedures will mitigate the risk," 28 C.F.R. § 36.208(c), to the point of "eliminating" it as a "significant risk," 42 U.S.C. § 12182(b)(3). See also *Bragdon v. Abbott*, 141 L. Ed. 2d 540, 118 S. Ct. 2196, 2210 (1998) (explaining that "[b]ecause few, if any, activities in life are risk free, *Arline* and the ADA do not ask whether a risk exists, but whether it is significant"). Under the ADA, a failure to make a reasonable modification is itself an act of discrimination unless the place of public accommodation can demonstrate that implementing the modification would fundamentally alter the nature of the program. *See* 42 U.S.C. § 12182(b)(2)(A)(ii).

In this case, U.S.A. Bushidokan concedes that its karate school is a place of public accommodation subject to the

requirements of Title III, *see* 42 U.S.C. § 12181(7)(L), and that Michael Montalvo is disabled for purposes of the ADA by virtue of being HIV-positive or having AIDS, *see* 42 U.S.C. § 12102(2)(A). n3 U.S.A. Bushidokan also concedes that it denied Michael participation in group karate classes on the basis of his HIV-positive status, the condition that concededly constitutes his disability. But U.S.A. Bushidokan contends that its exclusion of Michael was legally justified because Michael posed a "direct threat" to other members of the karate class. This contention presents two issues: (1) whether Michael's condition posed a significant risk to the health or safety of others and (2) whether reasonable modifications of policies, practices, or procedures were available to eliminate the risk as a significant one. *See* 42 U.S.C. § 12182(b)(3).

n3 Because U.S.A. Bushidokan does not contest Michael's claim that he is disabled as defined by the ADA, we need not address the issue further. *Cf. Bragdon,* 118 S. Ct. at 2207 (holding that the plaintiff, who was HIV-positive, was disabled because the major life activity of procreation was substantially impaired, but declining to reach the question of whether HIV-positive status is *per se* a disability).

A.

While the question of whether Michael's HIV-positive status posed a significant risk to the health or safety of others is a "fact intensive determination," *Rizzo v. Children's World Learning Centers, Inc.,* 84 F.3d 758, 764 (5th Cir. 1996), the evidence in the record before us is ample to support the district court's conclusion that Michael posed such a risk.

First, both the Montalvos' and U.S.A. Bushidokan's medical experts testified that blood-to-blood contact is a means of HIV

transmission, and both experts agreed that AIDS is inevitably fatal. In addition, U.S.A. Bushidokan's expert testified without challenge that it was possible to become infected with the virus from blood splashing into the eyes or onto seemingly intact skin.

Second, the type of activity offered at U.S.A. Bushidokan emphasized sparring, attack drills, and continuous body interaction with the result that the participants frequently sustained bloody injuries, such as nose bleeds, cuts inside the mouth, and external abrasions. Radcliffe testified that blood from those injuries is "extremely likely" to come in contact with other students' skin. Even though U.S.A. Bushidokan had a policy of constantly monitoring for bloody injuries and removing for treatment participants with those injuries, the fast-paced, continuous combat exercises hampered U.S.A. Bushidokan's efforts to eliminate contact when such injury occurred.

From these facts and other similar evidence, the district court found that there is "a high frequency of minor but bloody abrasions among the students" and that the blood from such injuries is "extremely likely" to spill onto the hands, uniforms, and mouths of other students. The court also found that because of this likelihood and because of the ineffectiveness of the "universal precautions" for handling blood in the context of this hard-style karate, the risk of a student's transmitting HIV to another student was "significant." We agree.

The nature, duration, and severity of the risk and probability of transmission -- factors outlined by *Arline* and the ADA regulations -- indicate that a significant risk to the health and safety of others would exist if Michael were allowed to participate in the group karate classes. *Cf. Doe v. University of*

Maryland Medical Sys. Corp., 50 F.3d 1261 (4th Cir. 1995) (holding that a hospital could terminate the residency of an HIV-positive surgical resident on the ground that the individual was not "otherwise qualified" for his position because he posed a significant risk to others). The nature of the risk, which Arline defines as the mode of transmission of the disease, *see* 480 U.S. at 288, is blood-to-blood or blood-to-eye contact, according to the testimony of both sides' experts. The duration of the risk, which *Arline* defines as how long the carrier is infectious, see *id.*, is for the length of Michael's life. The severity of the risk is extreme because there is no known cure for AIDS, and, as the Montalvos concede, AIDS is inevitably fatal. And although the exact mathematical probability of transmission is unknown, the mode of transmission is one which is likely to occur in U.S.A. Bushidokan's combat-oriented group karate classes because of the frequency of bloody injuries and body contact. Thus, the nature of the risk, combined with its severity, creates a significant risk to the health and safety of hard-style karate class members.

When balancing the *Arline* factors to determine whether a risk is significant, one need not conclude that each factor is significant on its own. Rather, the gravity of one factor might well compensate for the relative slightness of another. Thus, when the disease at risk of transmission is, like AIDS, severe and inevitably fatal, even a low probability of transmission could still create a significant risk. In this case, therefore, we agree with the district court that Michael's condition posed a significant risk to the health and safety of others.

The Montalvos challenge the district court's factual findings because they are supported by the testimony of Dr. Carey Bruce Savitch, the medical expert who testified on behalf of U.S.A. Bushidokan. They maintain that Dr. Savitch testified to

conclusions that did not follow from scientific premises and that, therefore, his conclusions should be disregarded. We note, however, that Dr. Savitch's conclusions were not critical to the district court's factual findings since the Montalvos' expert reached essentially the same conclusions about the nature of transmitting HIV. But even if Dr. Savitch's testimony had been important to the district court's findings, the Montalvos' argument could not succeed because the Montalvos failed to object to Dr. Savitch's testimony during trial in the district court. *See C.B. Fleet Co., Inc. v. SmithKline Beecham Consumer Healthcare, L.P.*, 131 F.3d 430, 437 (4th Cir. 1997).

The Montalvos also argue that Dr. Savitch was merely a private physician and that his testimony should therefore be accorded less weight than that of public health authorities. It is true, as the Supreme Court recently observed, that in assessing the reasonableness of a place of public accommodation's decision to refuse service to an individual with a disability because of an alleged direct threat to the health or safety of others, the views of public health authorities, while not conclusive, "are of special weight and authority." *Bragdon*, 118 S. Ct. at 2211. But this argument does not advance the Montalvos' cause because their case was also not supported by any evidence from public health authorities. On appeal, they do cite a number of medical journals and public health publications for the first time in their brief, but we will not consider factual evidence that was not presented at trial.

Even if we were to consider the materials submitted by the Montalvos for the first time on appeal, they would not alter the outcome of this case. The bulk of the Montalvos' citations refer either to the fact that people who are HIV-positive face great personal and social challenges or to studies regarding the

transmission of HIV between dentists and patients. The former fact, which is most unfortunately true, only reinforces the view that Michael's classmates should not be subjected to any significant risk of HIV transmission, and the studies of HIV transmission between dentists and patients are irrelevant to ascertaining the risk of transmission existing during hard-style karate sparring. The likelihood of exposure to blood is different for the two activities.

The experts in this case agreed that HIV can be transmitted through blood-to-blood contact, and the evidence showed that this type of contact occurred frequently in the karate classes at U.S.A. Bushidokan. Thus, the district court's finding that Michael Montalvo posed a significant risk to the health or safety of others is amply supported by the evidence.

B.

Even though Michael Montalvo's condition posed a significant risk to the health or safety of others, U.S.A. Bushidokan would still be required to admit him to group karate classes if a reasonable modification could have eliminated the risk as a significant one. *See* 42 U.S.C. § 12182(b)(3). The only modification which was both effective in reducing risk to an insignificant level and in maintaining the fundamental essence of U.S.A. Bushidokan's program was its offer of private karate classes to Michael.

In considering other modifications, U.S.A. Bushidokan was entitled to reject the modification that would soften the teaching style of its program. U.S.A. Bushidokan's unique niche in the martial arts market was its adherence to traditional, "hard-style" Japanese karate, and the contact between participants, which causes the bloody injuries and creates the risk of HIV

transmission, was an integral aspect of such a program. To require U.S.A. Bushidokan to make its program a less combat-oriented, interactive, contact intensive version of karate would constitute a fundamental alteration of the nature of its program. The ADA does not require U.S.A. Bushidokan to abandon its essential mission and to offer a fundamentally different program of instruction. *See* 42 U.S.C. § 12182(b)(2)(A)(ii).

Similarly, U.S.A. Bushidokan was not required to implement further "universal precautions" such as using eye coverings and wearing gloves. The district court found as a fact that these modifications would not accomplish their goal of eliminating or reducing the otherwise significant risk Michael would pose to his classmates. As Radcliffe testified on behalf of U.S.A. Bushidokan, the suddenness of injuries, the tendency of some wounds to splatter blood, the continuing movement and contact, and the inability to detect injuries immediately all would undermine the effectiveness of these precautions, particularly for places not protected by eye coverings, gloves, or other similar coverings.

U.S.A. Bushidokan did propose the effective modification of giving Michael private karate lessons, and the district court found this modification reasonable. But the Montalvos rejected this proposal. While an ADA plaintiff is under no obligation to accept a proffered, otherwise reasonable modification, *see* 28 C.F.R. § 36.203(c)(1) ("Nothing in this part shall be construed to require an individual with a disability to accept an accommodation . . . under this part that such individual chooses not to accept"), such rejection does not impose liability on U.S.A. Bushidokan for failure to modify its program.

Accordingly, we conclude that U.S.A. Bushidokan, in excluding Michael Montalvo from participating in its combat-

oriented group karate classes, did not violate Title III of the ADA because Michael posed a significant risk to the health and safety of others that could not be eliminated by a reasonable modification. The judgment of the district court is

AFFIRMED.

TAPE TRANSCRIPTION IN RE:
MONTALVO VS. RADCLIFFE
Argued: 10-26-98
Case Number: 98-1169
4th Circuit Court of Appeals

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THE CLERK: October 26, 1998, case Number 98-1169, Montalvo versus Radcliffe.

MR. RAINEY: Good morning, my name is Terry Rainey. I am the representative of Michael Montalvo the petitioner, appellant in this case. With me is Mr. Steve Aden, co-counsel for the Rutherford Institute. The facts of this case are Michael Montalvo has AIDS. Michael Montalvo's father applied to U.S.A Budocon, the defendant in this case, by Mr. Radcliffe to have karate lessons for his son, Michael. Mr. Radcliffe discovered some way that Michael had AIDS and asked Mr. Montalvo about that. Mr. Montalvo obtained from Dr. Susan Lavoy, who is treating physician for Michael Montalvo, who is an infectious disease doctor at Medical College of Virginia a certificate of statement that Michael Montalvo was fit to participate in karate. This wasn't good enough for Mr. Radcliffe. Mr. Radcliffe refused to let Michael participate in karate. Mr. Radcliffe did offer the accommodation of private lessons.

THE COURT: Let's move on a litle bit to the question of if the facts found by the district court are supportive, and I will make that -- set aside but for the moment -- if the facts are supportive, what is your case? The district Judge found that when you engage in this karate, there is a lot of bleeding contact and that --

MR. RAINEY: It was --

THE COURT: If there was injury, it was very likely that there would be clear risk of AIDS.

MR. RAINEY: If the facts are supported by the district court, I can go home right now, sir.

THE COURT: Well, I understand, but I want to understand what the issues are. So that if the facts are supported, you agree that the statute requires or supports the karate center's decision in this case?

MR. RAINEY: Correct.

THE COURT: So now the question is whether the facts that the district court found in support -- as I recall we have a couple of experts and we have testimony from the two members of the karate center who testified that there was blood everywhere, right?

MR. RAINEY: That is correct. The one thing that has occurred since the briefs in this case were filed is that Greg 118th Street Court 2196 [*sic* - *Bragdon v. Abbott*, 118 S.Ct. 2196 (1998)] --

THE COURT: -- people are coming to this case, there may be a question as to whether a 12-year-old has a disability under the act, but I think the other side has conceded it for purposes of this discussion.

MR. RAINEY: It has, sir.

THE COURT: Or at least maybe they have, I don't know they should have conceded it, because you have to ask the question was the life function, that is clear, but set that aside. The question I guess is why aren't the facts supported?

MR. RAINEY: Okay, the facts aren't supported because we have Harlan requires an objective evaluation of the facts, how is the disease transmitted, how long is it contagious, what are the means of transmission, what is the severity.

THE COURT: Still don't --

MR. RAINEY: The only testimony in this case of a medical basis is Dr. Susan Lavoy [*sic* - Lavoie] who is the treating physician for Michael Montalvo, who testified that Michael was okay to be in karate lessons.

THE COURT: That is not quite fair. She gave a testimony that he was fit to be in karate, but her testimony is categorically in agreement with every other testimony on how you transmit AIDS and what the risk is. And she said well blood transmits AIDS.

MR. RAINEY: That is correct.

THE COURT: And she wasn't evaluating blood on

blood. She was evaluating -- her testimony is -- there isn't a question about the fact where you have blood contacting blood there is a risk of AIDS in the transmission.

MR. RAINEY: That's correct.

THE COURT: So now what is wrong with the finding that when these kids engage they get bloody and touch each other, engage bloody noses, bloody lips, inside of the mouth pieces, it is all over their clothes. That was the testimony.

MR. RAINEY: Okay but what is wrong with that, sir, is that it is the defendant's burden to bring forward the probability or risk in connection with that. And there is no testimony which I submit it is the defendant's burden to bring forth of the probability of risk of what risk there would be to others if that situation came close. And it is the defense obligation to do that. The defense didn't do that, and I submit the trial court was incorrect.

THE COURT: How do you evaluate Dr. Savage's [*sic* - Savitch] testimony?

MR. RAINEY: I think Dr. Savage is a doctor who has a lot of opinions. He didn't give a basis for any of his opinions. He doesn't cite studies for his opinions. He doesn't cite research for his opinions. He simply is a doctor who has a lot of opinions. I don't think that Dr. Savage is entitled to any more belief than a person off the street who has opinions about AIDS.

THE COURT: Are you saying that there is a violation that Dr. Savage -- that perhaps in that case Dr. Lavoy neither of them are qualified?

MR. RAINEY: Dr. Lavoy is well qualified. The issue with Dr. Lavoy is her practice in infectious diseases, her experience with people who have AIDS and HIV and her specific knowledge of Michael Montalvo, his medical history, and her treatment of him. Dr. Savage never examined Michael Montalvo. Dr. Savage never even looked at the medical records of Michael Montalvo.

THE COURT: But board certified in internal medicine, infectious disease as 90 percent of his practice in infectious disease and 20 percent of his practice in HIV-AIDS.

MR. RAINEY: Yes, ma'am.

THE COURT: So it is simply the lack of personal examination of the --

MR. RAINEY: No, in terms of his opinion about how the public health policy should be in regard to AIDS he doesn't base that on any scientific studies. He doesn't base that on any practice that he has performed. It is his opinion.

THE COURT: Well, the testimony which I think is undisputed -- you can tell me if I am wrong. I am reading page 34. This is Lavoy testifying. I talked about ten occurrences where Michael had an open wound. It was bleeding. And another person had an open wound and was bleeding. I gave him potential for risk of transmission in that case. I couldn't tell you what the exact percentage of transmission would be. Now, she said it is low, but there is a transmission risk.

MR. RAINEY: That's right.

THE COURT: Everybody seems to agree with that conclusion.

MR. RAINEY: That's right.

THE COURT: Now we have factual findings that when these young kids engage in this karate, they have that possible risk.

MR. RAINEY: Because of our case, Your Honor, page 85 Mr. Radcliffe and in essence what he said I did not contact Dr. Lavoy to explain any of this to her. Question: did you consult with any medical practitioner of your own about Michael's status or participating in your program? Answer: No, I did not. The defense has not carried its burden to show the risk of probability. They simply hysterically said, AIDS, oh my golly, somebody is going to get sick. We can't let this kid into my program. So that is the main point, Your Honor. The

defense has not brought forth the objective evidence as required by Harlan to support a conclusion that Michael was any sort of a health risk. And if that testimony on page 85, 86 wherein Mr. Radcliffe did nothing about this case in terms of trying to find out --

THE COURT: I am missing your point totally because it seems to me if we understand that AIDS is transmitted by blood contact with blood contact, open wounds, touching and all the protocols and everything trying to prevent that, and we have the activity where blood is exposed to blood when these kids compete, you don't need somebody to testify to the particular condition. He has AIDS. Nobody disagrees with that.

MR. RAINEY: That is correct.

THE COURT: The issue is the probability that transmission is going to take place. What if the probability is 2 percent? Where do we go from there under the statute?

MR. RAINEY: Then according to our view, we use the public health expert evaluation of whether or not that is a significant health risk which should exclude the disabled person.

THE COURT: Two percent of our kids are going to get AIDS and presumably die from it. Both doctors said so.

MR. RAINEY: Sir, if it were two percent, and I am not a medical expert, my conclusion would be that that would be significant. If it is far less -- 1 suggest it is far less, I think we have in our brief offered evidence to that effect that no, I don't think the risk is significant. And I don't think Michael should be excluded.

THE COURT: The evidence or some of the documentation that you have offered with your appellate brief, was that presented to the district court?

MR. RAINEY: No, ma'am, it was not.

THE COURT: Then how can we consider it?

MR. RAINEY: Well, you can consider it because it is extracted from appellate cases and it is part of those appellate

cases that have been decided. And one of the things that the Court can consider is a remand of this case for further development of the expert and technical evidence as may be required to decide this case.

THE COURT: Thank you very much.

MR. RAINEY: Yes, sir.

THE COURT: Mr. Collier.

MR. COLLIER: My name is Nathaniel Collier. I represent U.S.A. Budocon and Mr. Radcliffe. The first point I would like to address, Your Honors, is the idea that we should remand this case and the idea that this testimony will be presented for the first time in briefs should be admitted. If in fact these studies have come from particular deciding cases, I certainly didn't find any reference that agreed to which deciding cases they came from. Even if they came from deciding cases, I don't think that opens up the rule that you present your evidence at trial. You don't present your evidence for the first time on appeal.

Second in terms of the public authorities, no information regarding public health authority was submitted by the plaintiff at trial. I will submit to Your Honors that if you read the Harlan case in light of -- footnote, the Greg case -- that the public health authorities are not the only source that can be considered that in fact private opinions, private physicians can be used to provide the evidence necessary to show the risk of transmission.

Your Honor, I would submit to you that before we even get to Dr. Savage's testimony, that the case is pretty much decided on Dr. Lavoy's testimony. On cross examination Dr. Lavoy acknowledged certain things which quite frankly I received a real education in this case, the fact that you can brush your teeth and that that act of brushing your teeth can cause your saliva to be infected with blood which contains the HI virus, the fact that if you are punched in the fase any kind of agitation actually increases what is already being present in the

saliva in the mouth. Her testimony was very clear in terms of the open wounds. And if you read it in the light of Mr. Radcliffe's testimony, which was unrebutted, the number of blood injuries, not major injuries, but the number of blood injuries that occur and the fact that it can occur on both parties and the fact that given the nature. And specifically I addressed it in the district court, and I would like to address it here. We don't just punch and step away. This is a hard-core, if you will, karate program. That is why quite frankly I don't have my child there, but it is there to serve a purpose. And the number of instances in which one or more combatants draw blood from the other is just, it is amazing when you look at it in the context with this case. Now, what is the percentage, I don't know that -- you ask the doctor to look at percentages. Dr. Lavoy can't answer that question. Dr. Savage can't necessarily answer that question. And I don't think that anybody can answer that question. So the percentage I think that stands out in this case, which is really goes to the heart of this issue is the percentage of 100 percentage and 100 percent of people who will die once they are HIV infected. I would submit to Your Honor that even if there is a remote risk that the 100 percent is the ruling percent which should be contemplated.

THE COURT: Let me direct you to the statute and ask you this question. Who has the burden of showing that a reasonable modification cannot be made?

MR. COLLIER: I believe that we have the burden of showing that a reasonable modification could not be made.

THE COURT: Why do you say that?

MR. COLLIER: Well --

THE COURT: The statute said purposes of subsection A discrimination includes a reasonable modification.

MR. COLLIER: That is correct.

THE COURT: Who has the burden of proof in the discrimination?

MR. COLLIER: Well, I believe the plaintiff has the burden of proving the discrimination initially. And once the -- and you addressed this earlier, Your Honor, and I will touch on it. My gut feeling was that after reading the legislative history and reading what was available from the various courts, my gut feeling was that eventually we were going to be looking at HIV as a disability within itself. In this particular case I was aware that Michael Montalvo had AIDS or was symptomatic with AIDS and felt very strongly that it was going to be a disability and so that issue was essentially conceded.

THE COURT: Why do you say it is a disability? What is a disability under the --

MR. COLLIER: Well, the rationale but I don't necessarily agree with it from a personal standpoint, but I am not able to stand in the shoes of the Supreme Court. The rationale I believe is that it effects on one of the essential life functions, which --

THE COURT: -- Well, this is a 12-year-old kid. At that point you are assuming -- determination that that life function is impaired. How about an eight-year-old kid? Would you agree there he is disabled?

MR. COLLIER: Again, I agree with the legislative history. I agree the act was intended to cover the situation, yes, sir.

THE COURT: What is the life function of an eight-year-old kid?

MR. COLLIER: I suppose it would be the future potential appropriate age.

THE COURT: Do you know whether anyone has ever looked at the issue of children's -- a child, for example a child seems to be able to participate in school. A school is not the equivalent of work you might say for providers, compared to an adult. I don't know if anybody has ever looked at that, but it is not really an issue in this case.

MR. COLLIER: I don't believe so. I think this is a 12.82B3 case. The question is whether there was a significant risk. And I think we proved -- number one we have proved through Dr. Savage's testimony, it was unrebutted. It was only rebutted in the brief. Defense signed an order allowing all of this testimony to come in, and it was completely unrebutted. But again I addressed this in the brief, I think the major issue is decided on Dr. Lavoy's testimony. Dr. Lavoy testified very frankly and in the context of this particular case where you have blows being thrown to the facial area, I think her testimony is critical. If you look at the testimony dealing with the cornea, the particular susceptibility of the eye. When blood enters the eye, surgeons take precautions to avoid having blood enter the eye because there is a particular susceptibility through the eye through the cornea. And if you envision the situation that was testified to by Mr. Radcliffe in terms of the number of blood-splashed injuries, it is not difficult to imagine one of these situations arising in that karate class where blood is going to come in contact with either an open wound or the eye.

THE COURT: Did the plaintiff in this case identify any modifications that he wanted?

MR. COLLIER: The plaintiff suggested universal precautions could be used. Dr. Lavoy testified that that could not be the case.

THE COURT: What universal precautions?

MR. COLLIER: Well, that kind of clouds the issue, Your Honor. My expert, Dr. Savage, testified that total body armor would be the only universal precaution to be used in this particular case. Dr. Lavoy discussed how quickly the wound should be cleaned, things of this nature. Mr. Radcliffe clearly indicated that because of the nature of the sparring session that often the blood is not detected until too late to clean it up. And regarding the issue that Mr. Rainey discussed with Mr. Radcliffe not seeking medical assistance, Mr. Radcliffe has been

training in this program, a 40-hour program dealing in large part with blood pathogens. He is a police officer who has been trained. He has been trained to understand that HI infection can occur when precautions aren't taken, and he has been trained to understand the nature and know the facts found by the district court. And I think that your initial question for Mr. Rainey is the critical question in this case. This is a case in which the facts clearly, clearly support the decision of the Court. And there has been absolutely nothing presented to show that those facts, that that decision of the district court based on those facts was clearly erroneous. We have two medical experts, both of which testified that there is a substantial risk or that there is a risk of transmission. And we have the experts that agrees that the disease once transmitted is one hundred percent fatal. Judge Williams found these things and decided these facts. He further found that it is impossible given the nature of the style of this particular karate lesson -- this is not your average Tae Kwon Do karate classes. He found that because of the nature of that particular karate class, it was impossible to allow HI infected individuals in the classroom because the blood splatters so frequently and so quickly. And this is where it cannot be detected, that no other precaution could be used. If you look at the testimony of Mr. Radcliffe, he feels the discussions with Mr. Montalvo -- it is clear that he discussed alternatives with Mr. Montalvo. Mr. Montalvo cut him off at the past. Mr. Montalvo said you are talking about private lessons. We don't even want to hear about it. Mr. Montalvo lied even in the beginning to get Michael into the class and subjected the other students to risk at that point when they didn't even know the risk that they were being subjected to, gave then no opportunity to defend themselves or remove themselves from the situation. Judge Williams addressed that in deciding the facts and did not really focus on any conclusions of law. I think it is something that the Court should consider as well.

THE COURT: Well, that is not something we should hold Michael responsible for.

MR. COLLIER: I agree. That is probably why it doesn't appear in any conclusion law. I think it is struck, Your Honor, and I think it had impact, but I don't think -- for that reason, I don't think it did -- conclusion of law.

THE COURT: To folow up with the Judge's question about the burden, I guess the entity does have the burden of showing if there is a modification requested you do have the burden of showing that that fundamentally altered nature of the program that is being provided.

MR. COLLIER: Yes, ma'am, again Judge Williams found that as a matter of fact that the modification would -- he found that it would just remove him from the marketplace, that they are a unique provider. And the American disability acts specifically said that the accommodation doesn't have to do that. That is not the requirement of the law.

THE COURT: You throughout your briefs, accommodation from the employment section of the act, there is no accommodation required in this act called modification which makes it different from the employment modification.

MR. COLLIER: Even so I agree clearly the reading of the act would not require a -- or a school such as the karate studio to abandon his primary purpose and to, again, to completely alter the program to the point where it was no longer able to offer the program. This is not your average karate studio. And that was the point that was made very early on about Mr. Radcliffe. This is a unique situation. This is a situation where children are fighting. It involves the same danger or probably more danger than if you were a boxer getting into the rink together, one being HIV positive and the other one not. It is simply too large of a risk for these children and for the instructors of this program to have to endure. That is what Judge Williams found after hearing all of the evidence.

And I -- the evidence that was presented in the brief -- I don't believe the Court is going to consider the evidence that was presented for the first time in the appellants brief, but the record is clear the accommodation was offered. And there is absolutely nothing that Mr. Radcliffe could have done outside of completely altering the nature of this program that would have accommodated Michael Montalvo.

THE COURT: Thank you very much.

MR. COLLIER: Thank you.

THE COURT: Mr. Rainey.

MR. RAINEY: In rebuttal, the first point, for you all to reverse this case, you do have to find that the findings of fact in the trial court below were all erroneous. And I realize that you would be putting --

THE COURT: Clearly erroneous.

MR. RAINEY: Clearly erroneous, I realize that that is a difficult standard to overcome. I will specifically point to the one position, the one proof of medical evidence that you have is from Dr. Lavoy. And number two, Judge, you talk about risk, that is the whole point. We have no point or occasion of risk in here. Let me use a historical example.

THE COURT: Sir, you have to read the brief, the statute. You haven't cited -- you are not interpreting the statute. You are talking about something that is foreign to what we have to consider. The statute provides the whole standard, not a direct threat, and then it terms the risk must be a substantial risk. It doesn't talk about what qualification. The question is as a matter of law what is a substantial risk.

MR. RAINEY: Okay.

THE COURT: To the safety of others.

MR. RAINEY: We have Harlan [*sic - Arline*]. In Harlan one of those factors was the probability that the harm will occur. And in our case we have nothing from the defense of probability. We hear phrases like there is a remote risk, it is too

large of a risk. Back in the '40's, we excluded a whole class of American citizens.

THE COURT: What are you suggesting is significant risk? How would you have us go about defining what is a significant risk?

MR. RAINEY: I am suggesting it is the defendant's responsibility and burden to bring that information forward.

THE COURT: You are not answering my question. My question is what is a significant risk?

MR. RAINEY: I don't know, sir. I think that is a medical expert question to be presented to the Court and the Court has got --

THE COURT: Why isn't that just a causation question?

MR. RAINEY: We know what the cause is. The --

THE COURT: Well, your cause -- how significant?

MR. RAINEY: We know when HIV is contracted everybody agrees that it is 100 percent fatal.

THE COURT: Now what is a significant risk to that in a context of a sport where blood is spilled?

MR. RAINEY: What we don't know and what wasn't presented by the defense in this case is when you have blood to blood contact what is the probability that an infection will take place.

THE COURT: Well, you need a probability. All you have to answer is whether that is significant.

MR. RAINEY: Because that is the Harlan's standard is part of the evaluation, the probability that the infection will take place. And if the probability is zero, then Michael has been improperly discriminated against based on hysteria, not based on any medical fact. If the probability is above zero, then it becomes a judgment call. And where that line breaks, sir, I do not know.

THE COURT: Let me ask the question I asked your opponent, what is -- who carries the burden on showing

whether a reasonable modification should be made? The statute said for purposes of subsection A the section of discrimination includes a -- to make a reasonable modification. Then of course it said that if one is -- with it, then clearly the karate center has the burden of showing that it would fall under the to alter the nature of the service.

MR. RAINEY. Sir, I think the burden of reasonable modification is on the discriminating party. And in this particular case I think Mike was clearly shown discrimination, discrimination based on AIDS. And it is now up to the defense, the karate studio, to show that the accommodation or the modification was reasonable under the circumstances.

THE COURT: Well, what modification do you want?

MR. RAINEY: We do not want that modification.

THE COURT: You do not want that modification? Your view is you can participate In the program as designed?

MR. RAINEY: Yes, sir.

THE COURT: Okay.

MR. RAINEY: Let me give you a by historical example, we excluded American citizens of Japanese ancestry on the remote possibility that somebody may do something treacherous during World War II. I think all the world agrees now that that was a hysterical decision. That was the type of wrong-headed policy that develops when all we do is talk about the remote possibility that someone somewhere may do something bad. We punish thousands and thousands of American citizens because of the hysterical idea that if you were of Japanese ancestry, you were going to --

THE COURT: That is a far cry from the situation where you have universal precautions which suggest using gloves, not having contact with blood, protecting eyes, protecting contact with open wounds. It seems to me you are talking about a situation where you can transmit a fatal disease in any manner where blood is contacted with blood. There is not much dispute

about it. The question is how much contact, what is the nature of the risk, and what are the precautions to be taken.

MR. RAINEY: That's correct, sir.

THE COURT: We are not talking about the Japanese possibility where because you are Japanese, you are therefore a part of the enemy, are we?

MR. RAINEY: Well, what we are talking about here is what I would suggest is a hysterical conclusion that just because we have AIDS, we have to exclude everyone from the possibility of participating in a program where some physical injury including the cutting may occur. And where what the defense have shown as to any probability that that cutting leads to a transmission that caused the disease to infect or not infect a person. And we are excluding a whole class of disabled people from participation in a physical program simply of the hysteria of, "Oh, my golly, it might happen." And we don't have the factual basis for the, "Oh, my golly, it might happen."

THE COURT: Well, isn't this case that we have in front of us today the only program that we have in front of us is a particular form of karate school? That in fact they have gone to some length to distinguish themselves from the ordinary sort of family karate school where the result might be quite different? We don't have that.

MR. RAINEY: That is true. I would suggest to you that the intellectual process in this case was, "Oh, my golly there might be a disease transmission therefore the diseased person cannot participate."

THE COURT: Okay.

MR. RAINEY: I have nothing additional unless you have additional questions for me.

THE COURT: Thank you very much. We'll come down and meet counsel.

CERTIFICATE OF COURT REPORTER

I, Cheree Worley, hereby certify that I was the Court Reporter; further, that the foregoing is a true and accurate record of the testimony and other incidents of the hearing herein to the best of my ability.

Given under my hand this 14th day of April, 1999.

Cheree Worley, RPR
Notary Public

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

Richmond Division

Luciano Montalvo, individually and as the parent and guardian of Michael Montalvo Plaintiff, v. James P. Radcliffe, II; Southside Virginia Police Karate Association, Inc. Dba U.S.A. Bushidokan Defendant.	)	Civil Action No. 3:97cv487

FINAL ORDER

This matter is before the Court for findings of fact and conclusions of law. For reasons set forth in the accompanying 'Findings of Fact and Conclusions of Law,' the case is DISMISSED WITH PREJUDICE as to all defendants.

It is so ORDERED.

Let the Clerk send a copy of this Order to all counsel of record.

JAN 29 1998
DATE

/S/ Richard L. Williams
SENIOR UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

Richmond Division

Luciano Montalvo, individually and as the parent and guardian of Michael Montalvo	)	
Plaintiff,	)	
v.	)	Civil Action No. 3:97cv487
James P. Radcliffe, II; Southside Virginia Police Karate Association, Inc. Dba U.S.A. Bushidokan	)	
Defendant.	)	

FINDINGS OF FACT and CONCLUSIONS OF LAW

This matter is before the Court for findings of fact and conclusions of law following a bench trial January 22, 1998. Upon consideration of trial testimony and review of the record and its supporting documentation, the Court makes the following findings of fact and conclusions of law.

A. Findings of Fact

1. James P. Radcliffe, II is the sole stockholder and president of Southside Virginia Police Karate Association, Inc., a Virginia corporation, d/b/a U.S.A. Bushidokan in Colonial Heights, Virginia, 23834. U.S.A. Bushidokan is a school for the

instruction of the martial arts in the city of Colonial Heights, Virginia, 23834.

2. The nature of the martial arts instruction at U.S.A. Bushidokan in Colonial Heights, Virginia consists primarily of instruction in "hard-style Japanese karate." This instruction is comprised of a regimen of defensive and counter-attack instruction with a heavy emphasis on sparring and actual-fight simulation. Training is often characterized by students pairing off with one another for the purpose of executing multiple repetitions of specific self-defense techniques. Moreover, students at U.S.A. Bushidokan frequently engage in kumite, or sparring, where students may use any number of karate or grappling techniques to defeat their opponents in a mock "street fighting" setting. Finally, students engage in training drills where one student may be instructed to defend himself or herself against a continuous series of "attacks" from several other students. (J.P. Radcliffe, Tr. Test.)

3. In contrast to most of the martial arts schools which today have become increasingly commercialized and 'family fitness' oriented, U.S.A. Bushidokan is a martial arts school dedicated to the teaching of self-defense and effective fighting techniques. Accompanying the strong emphasis on sparring is a high frequency of minor but bloody abrasions among the students at U.S.A. Bushidokan. (J.P. Radcliffe, Tr. Test.) For instance, students frequently receive nosebleeds and minor cuts and abrasions inside of their mouths as a result of sustaining strikes during sparring. (J.P.Radcliffe, Tr.Test.; Def. Tr. Exh. 2 and 4).

4. When a student sustains a bloody injury while training at U.S.A. Bushidokan, the bleeding that results from the injury is extremely likely to spill onto either the student's

hands, his/her uniform, his/her mouth, or even onto the students with whom he or she is training. (J.P. Radcliffe, Tr. Test.; Def. Tr. Exh. 2,3, and 4.) In addition, because many of the minor abrasions that occur are nosebleeds and mouth abrasions, blood from these injuries may mix with the student's saliva or mucus which could also spill onto the students with whom the student is training. When these facts are viewed in light of the large number of students who simultaneously train at U.S.A. Bushidokan, it is clear that it is simply impossible for the instructional staff to attend and treat with vigilance each abrasion immediately after it occurs, (J.P. Radcliffe, Tr. Test)

5. As set out by trial testimony and the supporting record, "universal precautions" exist for the treatment and handling of blood flowing from a wound or abrasion. U.S.A. Bushidokan is governed by a self-imposed regulation that requires any bleeding student to cease his/her activity immediately after sustaining an injury and seek prompt and proper treatment for the bleeding before returning to training. (J.P. Radcliffe, Tr. Test.) Because self-monitoring by students at U.S.A. Bushidokan is the primary method of initiating the treatment process for any bleeding that occurs, and given the "continuous" nature of the activities involved, a strict adherence by U.S.A. Bushidokan to the"'universal precautions" would most likely be completely ineffective in preventing the spillage of blood, mucus, or saliva. (LaVoie Depo, 30; J.P. Radcliffe Tr. Test).

6. The rigorous training regimen provided at U.S.A. Bushidokan simply makes it impossible for the instructional staff make minute-by-minute, exercise-by-exercise determinations as to whether a student is bleeding in any way whatsoever.

7. U.S.A. Bushidokan adheres to the vigilant practice of pulling from active training any student who is bleeding and treating that student according to proper medical procedures. (J.P. Radcliffe, Tr. Test) In spite of the conscientious and effective treatment procedures followed by U.S.A. Bushidokan to treat bloody injuries, the nature of the training and the sheer number of "mutual combat" exercises that occur at the same time make it an undeniable fact that abrasions and cuts will inevitably go unnoticed for short periods of time before they are treated. (J.P. Radcliffe, Tr. Test)

8. Plaintiff Luciano Montalvo is the parent and natural guardian of plaintiff Michael Montalvo, now a twelve year old child.

9. Plaintiff Michael Montalvo has Acquired Immunodeficiency Syndrome ("AIDS").

10. A written document (the "Agreement") recorded the agreement between Plaintiff Luciano Montalvo and Defendants James P. Radcliffe, II, Southside Virginia Police Karate Association, Inc. d/b/a U.S.A. Bushidokan and Donna Radcliffe as School Manager of Southside Virginia Police Karate Association, Inc. d/b/a U.S.A. Bushidokan. (Pl. Tr. Ex. A and Def. Tr. Ex. 1).

11. The Agreement was signed by Donna Radcliffe as School Manager/Owner of U.S.A. Bushidokan and Luciano Montalvo as the parent and natural guardian of Michael Montalvo.

12. The Agreement provided an unlimited membership plan for Plaintiff, Michael Montalvo to participate in instructional classes, training sessions, demonstrations, seminars

and competitions conducted, held, or sponsored by U.S.A. Bushidokan.

13. In addition to setting forth the unlimited membership privileges that would be incumbent upon plaintiff, the Agreement imposes several 'Additional Terms and Conditions' that must be met in order for the Agreement to be binding between the parties who have signed the Agreement.

14. Among the 'Additional Terms and Conditions' enumerated in the Agreement is Condition 2, which states the following:

> 2 - Medical - Buyer and/or member hereby represents and warrants that he/she is in good health and that he/she suffers from no illness or condition which would in any way prevent him/her from carrying out the fitness program provided by the U.S.A. BUSHIDOKAN and/or which would possibly be infectious to others. It is understood that no member will use the facilities with any open cuts, abrasions, open sores, infections, maladies with the potential of harm to others, or otherwise in accordance with public health requirements. All members are strongly encouraged to have a complete physical examination by a medical doctor prior to your participation in this program.

15. Dr. Suzanne LaVoie is a physician who is an expert in infectious diseases to include AIDS and HIV. Dr. LaVoie is on the staff and faculty of the Medical College of Virginia (MCV).

16. Dr. LaVoie is plaintiff Michael Montalvo's physician and is treating him for AIDS.

17. Luciano Montalvo provided to defendants a statement from Dr. LaVoie that Michael Montalvo was physically fit to participate in karate classes. (Pl. Tr. Ex. B).

18. Upon learning that plaintiff Michael Montalvo tested positive for the Human Immunodeficiency Syndrome ("HIV") or had AIDS, defendants refused to allow plaintiff to participate in the martial arts training classes provided at U.S.A. Bushidokan.

19. The defendants offered plaintiff Michael Montalvo private lessons in lieu of class instruction which plaintiff Luciano Montalvo refused.

20. According to Dr. LaVoie's sworn testimony:

A. Introducing infected blood into an open sore would cause a risk of transmission of HIV;

B. universal precautions dictated by current medical knowledge require medical personnel to wear eye protection to guard against the risk of blood spurting from a wound into the eyes;

C. under universal precautions surgeons are required to wear gloves when they operate even if they have no open wounds on their hands as a precaution from having blood spilled on the skin;

D. there are known cases of HIV transmission from such innocuous activities as sharing a toothbrush; and

E. once AIDS is transmitted, it is 100% fatal. (LaVoie Tr. Test; LaVoie Depo., 36, 44).

21. Dr. Carey Bruce Savitch is a physician who is an expert in infectious diseases with twenty percent of his practice devoted to HIV and AIDS. (Savitch Depo, Summ.).

22. According to Dr. Savitch's testimony:

A. The HIV virus can be transmitted by introducing the blood of one person who is HIV positive into a wound of another person; (Savitch Depo., 10)

B. "universal precautions," even when followed with exact precision, do not expunge the risk that persons coming into contact with HIV contaminated blood, saliva, or other bodily fluids will contract HIV and AIDS; (Savitch Depo., 34)

C. HIV and AIDS can be transmitted when contaminated blood is splashed into the eyes or onto the skin, even in the absence of an open wound; (Savitch Depo., 34) and

D. when mucus or saliva containing HIV- or AIDS- infected blood comes into contact with the eyes, skin, open wound or abrasion on another person, there is a significant risk that the infection may be transmitted to that other person (Savitch Depo., 39-43).

23. Luciano Montalvo, acting as the parent and natural guardian of Michael Montalvo, did sign the Agreement containing Condition 2 with full knowledge that Michael Montalvo did not meet the requirements of Condition B. By doing so, Luciano Montalvo intended to cause Michael Montalvo to be placed into the martial-arts class held at U.S.A. Bushidokan. (Montalvo Tr. Test; J.P. Radcliffe Tr. Test)

24. Luciano Montalvo misrepresented to James P. Radcliffe, II and Donna Radcliffe on more than one occasion that Michael Montalvo was not HIV positive and/or that Michael Montalvo did not have AIDS.

25. At each point in time when Luciano Montalvo misrepresented the HIV status of Michael Montalvo in order to cause Michael Montalvo to be enrolled at U.S.A. Bushidokan, Luciano Montalvo possessed knowledge as to Michael Montalvo's true HIV status, and possessed a reasonable knowledge and understanding of the risks associated with the handling of blood of an infected person. (Montalvo Tr. Test.; Depo., 66).

26. If Luciano Montalvo had represented accurately the HIV status of Michael Montalvo, Donna Radcliffe would have refused to sign the Agreement enrolling Michael Montalvo as a student at U.S.A. Bushidokan. (D. Radcliffe Tr. Test.)

B. Conclusions of Law

1. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331 for claims arising under the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101 et. seq. There is an actual controversy between plaintiff and defendant.

2. Pursuant to 28 U.S.C. § 1391(b) venue is proper in this Court in that the events and omissions giving rise to the claims herein arose in the City of Colonial Heights, Virginia, which is within a geographical area within the jurisdiction of this Court.

3. As a preliminary matter, defense counsel made an in-court motion to dismiss the above captioned action against James P. Radcliffe, II in his individual capacity. The Court finds that James P. Radcliffe, II has been named in this lawsuit solely because of his status as the president and sole stockholder of the Southside Virginia Police Karate Association, Inc. d/b/a U.S.A. Bushidokan. For this reason, the defendant's motion to dismiss is GRANTED and the cause of action against James P. Radcliffe, II in his individual capacity is DISMISSED.

4. Defendant's business, U.S.A. Bushidokan, is a place of entertainment and recreation which is a "gymnasium . . . or other place of exercise or recreation" and thus is a public accommodation covered by the Americans with Disabilities Act, 42 U.S.C. § 12181(L).

5. The facts and the circumstances arising in this case create an obstruction to plaintiff Michael Montalvo's desire to train at U.S.A. Bushidokan. To the extent that plaintiffs condition as an individual infected with AIDS has caused him to be excluded from the martial arts classes at U.S.A. Bushidokan, plaintiff is a "qualified individual with a disability" within the meaning of 42 U.S.C. § 12111(8).

6. Plaintiff brings two causes of action in this case. First, plaintiff sues defendant for violations of the Americans with Disabilities Act. 42 U.S.C. § 12111 et. seq.. Second, plaintiff sues for violations of the Virginians with Disabilities

Act. Va. St. § 51.5 et. seq. The Court addresses each cause of action in turn.

7. To examine plaintiffs cause of action under the Americans with Disabilities Act, the Court conducts two distinct inquiries as set forth in the Act's prohibition of discrimination by public accommodations.

First, the Court must recognize that proper relief in this case must entail a distribution of rights and privileges that does not place the defendant in a position laden with undue health or safety risks. This principle is set forth in 42 U.S.C. § 12182(b)(3) which states:

> (3) Specific construction. Nothing in this title shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids or services.

When the Court applies this statutory analysis to the facts and circumstances of the case at hand, it is clear that ordering the defendant to allow plaintiff to train in group classes at U.S.A. Bushidokan would place the students, instructors, and all other relevant participants at U.S.A.Bushidokan in grave danger of contracting HIV and/or AIDS. The sworn testimony and the supporting record in this case have established clearly that the rigor and intensity of the training at U.S.A. Bushidokan coupled with the high frequency of minor but bloody injuries

among the students at U.S.A. Bushidokan create a setting in which participation by an HIV or AIDS infected individual such as the plaintiff would pose a direct threat to the health and safety of the other students.

Plaintiff may assert that the "universal" blood-handling precautions may provide a safe harbor for all personnel at U.S.A. Bushidokan who may come into contact with plaintiff's blood. However, the record is clear that the "universal precautions" would be far from effective, especially in a setting such as that present in martial arts classes at U.S.A. Bushidokan. Moreover, even in light of testimony by James Radcliffe regarding U.S.A. Bushidokan's conscientious and vigilant methods for handling and cleaning bloody injuries, the Court finds that these procedures could in no way insure that absolutely no blood or saliva or mucus bearing blood from any given student will ever come into contact with another student.

The record in this case and the sworn testimony of James P. Radcliffe, II illustrate with clarity that students often sustain minor cuts or abrasions in their mouths while engaged in sparring activity. Such activity most likely involves students training in pairs, often in very close contact with one another, and sometimes even in a "grappling" or wrestling mode. The record is equally clear that even if a student were to cease all fighting activity immediately upon notice that he/she is bleeding, a sufficient amount of time may have past for blood spillage onto another student or for saliva or mucus bearing blood to spill onto the skin, into a wound, or into the eyes of another student.

The Court is satisfied that instructional personnel at U.S.A. Bushidokan are knowledgeable, competent, and effective in noticing and treating bloody injuries among its

students. At the same time, however, the Court must recognize that in the training setting at U.S.A. Bushidokan at least some small amount of blood spillage from student to student is going to occur. This is precisely why the defendant requires its students to abide the special conditions set forth in the training contract, including the prohibition on students bearing infectious diseases or other maladies that may present "potential harm to others." (See Condition 2, Pl. Tr. Exh. A; Def. Tr. Exh. 1).

Simply stated, AIDS is one hundred percent fatal. The methods adopted by defendant for the treatment of bloody injuries are not going to be one-hundred-percent perfect. Therefore, placing plaintiff into a setting where he may sustain a bloody injury is likely, at some point in time, to present to the instructors and other students a substantial and very real threat of acquiring HIV or AIDS.

8. Having established that placing plaintiff directly into classes at U.S.A. Bushidokan would place the health and safety of plaintiffs instructors and fellow students at significant risk of acquiring HIV or AIDS, the Court must now assess whether a "reasonable modification" has been made available to the plaintiff. Such an analysis requires the Court to invoke language in the Americans with Disabilities Act which provides in relevant part, that discrimination includes:

> (ii) a failure to make reasonable modifications in policies, practice, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of

> such goods, services, facilities, privileges, advantages, or accommodations . . .

42 U.S.C. § 12182(b)(2)(a)(ii).

In order to undertake an analysis of what comprises a "reasonable" modification, the Court must address two integral inquiries. First, the Court must ask: Would it be possible for U.S.A. Bushidokan to modify the nature of its instruction to accommodate plaintiff without eliminating its essential function? The answer is 'no.' The record and testimony in this case have shown clearly that the rigor, intensity, and physical demands which characterize the "hard style Japanese karate" taught at U.S.A. Bushidokan define the very uniqueness of U.S.A. Bushidokan which has set it apart from nearly every other "martial arts" school.

If the Court were to order U.S.A. Bushidokan to shift its instructional methods away from its emphasis on kumite and "street fighting" techniques towards a "softer" style with an emphasis, for example, on katas, or "forms," the Court would essentially be ordering U.S.A. Bushidokan to remove itself from the market as a provider of unique services and reintroduce itself as simply another "family fitness" martial arts school. This the Court cannot and will not do. Forcing U.S.A. Bushidokan to alter their method of training in such a dramatic manner is not "reasonable" under § 12182(b)(2). It is well established that a modification is not "reasonable" if it eliminates the essential function of the enterprise in question. *Doe v. Univ. of Maryland Medical System Corp.*, 50 F.3d 1261, 1266 (4th Cir. 1995); *Cf. Bradley v. University of Texas MD, Anderson Cancer Ctr.*, 3 F.3d 922,925 (5th Cir. 1993)(per curiam)(noting impossibility of eliminating risk of percutaneous injury to individual through reasonable accommodation because to do so would eliminate

essential functions of employment), cert. denied, 510 U.S. 1119 (1994).

The second question the Court must ask in order to determine whether a "reasonable" modification is possible in this case is: Is the accommodation that the defendant offered to the plaintiff "reasonable?' The answer is 'yes.' In light of the circumstances which make group training by the plaintiff at U.S.A. Bushidokan an impossibility, the defendant has offered to provide private lessons to the plaintiff in lieu of class instruction.

Private lessons for the plaintiff is the most reasonable and equitable form of relief for two principal reasons. First, in a one-on-one setting, plaintiff's instructor will be able to focus effectively on any and all of plaintiffs special needs, including those that arise if and when he may sustain a bloody injury. Second, private lessons will not disrupt the structure and nature of the group classes at U.S.A. Bushidokan. Simply stated, the defendant can simultaneously train its students in the rigorous, intensive manner that it has adopted while providing specially tailored lessons for Michael Montalvo in private sessions.

In sum, plaintiff's claims under the Americans with Disabilities Act fail as a matter of law. Placing plaintiff directly into the martial arts classes at U.S.A. Bushidokan would present a direct threat to the health and safety of the instruction personnel and the students in violation of 42 U.S.C. § 12182(3). Forcing U.S.A. Bushidokan to alter the format of its instruction towards a"softer," less-rigorous style would be equally hazardous; it would eliminate the function of the training at U.S.A. Bushidokan and comprise an unreasonable modification in violation of 42 U.S.C. § 12182 (b)(2) and well-established case law. Finally, in light of the rigor and intensity of the

training at U.S.A. Bushidokan, defendant's offer to provide plaintiff with private lessons in lieu of class instruction is a "reasonable" accommodation under § 12182(b)(2).

9. Virginia Statutes Cause of Action: In his state law claim, plaintiff reallege[s] and incorporates by reference each and every allegation pertaining to his claim under the ADA, and alleges that defendant has violated the Virginians with Disabilities Act. Va. St. § 51.5-l (1997).

10. In regards to these state law claims, the Court incorporates by reference the reasoning employed to dismiss plaintiffs claims under the ADA and dismisses the state law claims as a matter of law.

11. Plaintiffs Prayer for Relief: In regards to plaintiff's prayer for judgment set forth in Section VII (l)(c), the Court finds (1) that the instructional staff at U.S.A. Bushidokan is competent and knowledgeable regarding precautionary measures which should be taken to prevent the transmission of blood-borne diseases, and (2) that there is no reason for the Court to believe that they will not maintain their knowledge and competence by continuing training andeducation in these matters.

12. The Court DENIES each and every remaining prayer for relief requested by the plaintiff;

13. This case is hereby DISMISSED WITH PREJUDICE as to all defendants.

It is so ORDERED.

Let the Clerk send a copy of this Order to all counsel of record.

JAN 29 1998
DATE

/S/ Richard L. Williams
SENIOR UNITED STATES
DISTRICT JUDGE

TITLE 42. THE PUBLIC HEALTH AND WELFARE

CHAPTER 126. EQUAL OPPORTUNITY FOR INDIVIDUALS WITH DISABILITIES

PUBLIC ACCOMMODATIONS AND SERVICES OPERATED BY PRIVATE ENTITIES

42 USCS § 12181 (1999)

§ 12181. Definitions

As used in this title:

(1) Commerce. The term "commerce" means travel, trade, traffic, commerce, transportation, or communication--

(A) among the several States;

(B) between any foreign country or any territory or possession and any State; or

(C) between points in the same State but through another State or foreign country.

(2) Commercial facilities. The term "commercial facilities" means facilities--

(A) that are intended for nonresidential use; and

(B) whose operations will affect commerce.

Such term shall not include railroad locomotives, railroad freight cars, railroad cabooses, railroad cars described in section 242 [42 USCS § 12162] or covered under this title, railroad rights-of-way, or facilities that are covered or expressly exempted from coverage under the Fair Housing Act of 1968 (42 U.S.C. 3601 et seq.).

(3) Demand responsive system. The term "demand responsive system" means any system of providing transportation of individuals by a vehicle, other than a system which is a fixed route system.

(4) Fixed route system. The term "fixed route system" means a system of providing transportation of individuals (other than by aircraft) on which a vehicle is operated along a prescribed route according to a fixed schedule.

(5) Over-the-road bus. The term "over-the-road bus" means a bus characterized by an elevated passenger deck located over a baggage compartment.

(6) Private entity. The term "private entity" means any entity other than a public entity (as defined in section 201(1) [42 USCS § 12131(1)].

(7) Public accommodation. The following private entities are considered public accommodations for purposes of this title, if the operations of such entities affect commerce--

(A) an inn, hotel, motel, or other place of lodging, except for an establishment located within a building that contains not more than five rooms for rent or hire and that is actually occupied by the proprietor of such establishment as the residence of such proprietor;

(B) a restaurant, bar, or other establishment serving food or drink;

(C) a motion picture house, theater, concert hall, stadium, or other place of exhibition or entertainment;

(D) an auditorium, convention center, lecture hall, or other place of public gathering;

(E) a bakery, grocery store, clothing store, hardware store, shopping center, or other sales or rental establishment;

(F) a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment;

(G) a terminal, depot, or other station used for specified public transportation;

(H) a museum, library, gallery, or other place of public

display or collection;

(I) a park, zoo, amusement park, or other place of recreation;

(J) a nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education;

(K) a day care center, senior citizen center, homeless shelter, food bank, adoption agency, or other social service center establishment; and

(L) a gymnasium, health spa, bowling alley, golf course, or other place of exercise or recreation.

(8) Rail and railroad. The terms "rail" and "railroad" have the meaning given the term "railroad" in section 202(e) of the Federal Railroad Safety Act of 1970 (45 U.S.C. 431(e)).

(9) Readily achievable. The term "readily achievable" means easily accomplishable and able to be carried out without much difficulty or expense. In determining whether an action is readily achievable, factors to be considered include--

(A) the nature and cost of the action needed under this Act;

(B) the overall financial resources of the facility or facilities involved in the action; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such action upon the operation of the facility;

(C) the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type, and location of its facilities; and

(D) the type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of such entity; the geographic separateness, administrative or fiscal relationship of the facility or facilities in question to the covered entity.

(10) Specified public transportation. The term "specified public transportation" means transportation by bus, rail, or any other conveyance (other than by aircraft) that provides the general

public with general or special service (including charter service) on a regular and continuing basis.
(11) Vehicle. The term "vehicle" does not include a rail passenger car, railroad locomotive, railroad freight car, railroad caboose, or a railroad car described in section 242 [42 USCS § 12162] or covered under this title.

HISTORY: (July 26, 1990, P.L. 101-336, Title III, § 301, 104 Stat. 353.)

42 USCS § 12182 (1999)

§12182. Prohibition of discrimination by public accommodations

(a) General rule. No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

(b) Construction.
(1) General prohibition.
(A) Activities.
(i) Denial of participation. It shall be discriminatory to subject an individual or class of individuals on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements, to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity.
(ii) Participation in unequal benefit. It shall be discriminatory to afford an individual or class of individuals, on

the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with the opportunity to participate in or benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to other individuals.

(iii) Separate benefit. It shall be discriminatory to provide an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with a good, service, facility, privilege, advantage, or accommodation that is different or separate from that provided to other individuals, unless such action is necessary to provide the individual or class of individuals with a good, service, facility, privilege, advantage, or accommodation, or other opportunity that is as effective as that provided to others.

(iv) Individual or class of individuals. For purposes of clauses (i) through (iii) of this subparagraph, the term "individual or class of individuals" refers to the clients or customers of the covered public accommodation that enters into the contractual, licensing or other arrangement.

(B) Integrated settings. Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.

(C) Opportunity to participate. Notwithstanding the existence of separate or different programs or activities provided in accordance with this section, an individual with a disability shall not be denied the opportunity to participate in such programs or activities that are not separate or different.

(D) Administrative methods. An individual or entity shall not, directly or through contractual or other arrangements, utilize standards or criteria or methods of administration--

(i) that have the effect of discriminating on the basis

of disability; or

(ii) that perpetuate the discrimination of others who are subject to common administrative control.

(E) Association. It shall be discriminatory to exclude or otherwise deny equal goods, services, facilities, privileges, advantages, accommodations, or other opportunities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

(2) Specific prohibitions.

(A) Discrimination. For purposes of subsection (a), discrimination includes--

(i) the imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered;

(ii) a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations;

(iii) a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility,

privilege, advantage, or accommodation being offered or would result in an undue burden;

(iv) a failure to remove architectural barriers, and communication barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles and rail passenger cars used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehicles or rail passenger cars by the installation of a hydraulic or other lift), where such removal is readily achievable; and

(v) where an entity can demonstrate that the removal of a barrier under clause (iv) is not readily achievable, a failure to make such goods, services, facilities, privileges, advantages, or accommodations available through alternative methods if such methods are readily achievable.

(B) Fixed route system.

(i) Accessibility. It shall be considered discrimination for a private entity which operates a fixed route system and which is not subject to section 304 [42 USCS § 12184] to purchase or lease a vehicle with a seating capacity in excess of 16 passengers (including the driver) for use on such system, for which a solicitation is made after the 30th day following the effective date of this subparagraph, that is not readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs.

(ii) Equivalent service. If a private entity which operates a fixed route system and which is not subject to section 304 [42 USCS § 12184] purchases or leases a vehicle with a seating capacity of 16 passengers or less (including the driver) for use on such system after the effective date of this subparagraph that is not readily accessible to or usable by individuals with disabilities, it shall be considered discrimination for such entity to fail to operate such system so that, when viewed in its entirety, such system ensures a level of service to

individuals with disabilities, including individuals who use wheelchairs, equivalent to the level of service provided to individuals without disabilities.

(C) Demand responsive system. For purposes of subsection (a), discrimination includes--

(i) a failure of a private entity which operates a demand responsive system and which is not subject to section 304 [42 USCS § 12184] to operate such system so that, when viewed in its entirety, such system ensures a level of service to individuals with disabilities, including individuals who use wheelchairs, equivalent to the level of service provided to individuals without disabilities; and

(ii) the purchase or lease by such entity for use on such system of a vehicle with a seating capacity in excess of 16 passengers (including the driver), for which solicitations are made after the 30th day following the effective date of this subparagraph, that is not readily accessible to and usable by individuals with disabilities (including individuals who use wheelchairs) unless such entity can demonstrate that such system, when viewed in its entirety, provides a level of service to individuals with disabilities equivalent to that provided to individuals without disabilities.

(D) Over-the-road buses.

(i) Limitation on applicability. Subparagraphs (B) and (C) do not apply to over-the-road buses.

(ii) Accessibility requirements. For purposes of subsection (a), discrimination includes (I) the purchase or lease of an over-the-road bus which does not comply with the regulations issued under section 306(a)(2) [42 USCS § 12186(a)(2)] by a private entity which provides transportation of individuals and which is not primarily engaged in the business of transporting people, and (II) any other failure of such entity to comply with such regulations.

(3) Specific construction. Nothing in this title shall require an

entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.

HISTORY: (July 26, 1990, P.L. 101-336, Title III, § 302, 104 Stat. 355.)

U.S. District Court
Eastern District of Virginia (Richmond)
CIVIL DOCKET FOR CASE #: 97-CV-487

Montalvo v. Radcliffe, et al — Filed: 06/27/97
Assigned to: Judge Richard L. Williams
Demand: $0,000 — Nature of Suit: 440
Lead Docket: None — Jurisdiction: Federal Question

jkt # in USCA : is :98- -01169

Cause: 42:12101 Americans with Disability (Public Accomodations)

LUCIANO MONTALVO, individually and as the parent and guardian of Michael Montalvo	Terry WilliamRaney [COR LD NTC] 8154 Forest Hill Ave, Ste.1 Richmond, VA 23235 (804) 272-5994
plaintiff	
v.	
JAMES P. RADCLIFFE, II	Nathaniel M. Collier, III [COR LD NTC] Nathaniel M. Collier, III, Attorney at Law 200 Lakeview Avenue, Suite C Colonial Heights, VA 23824 (804) 520-2319
defendant	

SOUTHSIDE VIRGINIA POLICE KARATE ASSOCIATION, INC.

Dba
U.S.A. Bushidokan

defendant

Nathaniel M. Collier, III
(See above)
[COR LD NTC]

DONNA RADCLIFFE

defendant

Docket as of February 17, 1998 1:51 pm

Proceedings include all events.

APPEAL CLOSED

6/27/97 1 COMPLAINT Filing Fee $ 150.00 Receipt # 43347 (jpar)

6/30/97 -- SUMMONS(ES) issued for James P. Radcliffe II, Southside Virginia & picked up by atty. (jpar)

7/8/97 2 SUMMONS Returned Executed as to James P. Radcliffe II, and Southside Virginia 7/7/97 Answer due on 7/27/97 (ahar)

7/24/97 3 ANSWER to Complaint by James P. Radcliffe II, Southside Virginia (Attorney Nathaniel M. Collier III), (adoh)

8/11/97 4 MOTION by Luciano Montalvo to file an Amended Compaint (ahar)

8/11/97 5 MEMORANDUM by Luciano Montalvo in support of [4-l] motion by Luciano Montalvo to file an Amended Compaint (ahar)

8/11/97 6 SCHEDULING ORDER setting Pretrial Conference for 9:30 (signed by Judge Richard L. Williams) Copies Mailed: yes (jpea)

8/13/97 -- Amended Complaint rec'd and placed on left. (adoh)

8/26/97 7 ORDER granting [4-l] motion by Luciano Montalvo to file an Amended Compaint which joins Donna Radcliffe as a party Dft. (signed by Judge Richard L. Williams) Copies Mailed: y (ahar)

9/2/97 8 AMENDED COMPLAINT by Luciano Montalvo amending [l-l] complaint against Donna Radcliffe (ahar)

9/4/97 -- SUMMONS(ES) issued for Donna Radcliffe and picked up by attorney's office. (adoh)

9/9/97 9 Rule 26(a) (3) Disclosure by James P. Radcliffe II, Southside Virginia (Expert witness report) (ahar) [Edit date 09/09/97]

9/17/97 10 SUMMONS Returned Executed as to Donna Radcliffe 9/15/97 Answer due on 10/5/97 (1sal)

9/22/97 11 MOTION by Southside Virginia, James P. Radcliffe II to Amend [3-l] answer by Southside Virginia, James P. Radcliffe II (ahar)

9/22/97 12 MEMORANDUM by James P. Radcliffe II, Southside Virginia in support of [11-l] motion by Southside Virginia, James P. Radcliffe II to File An Amend [3-l] Answer by Southside Virginia, James P. Radcliffe II (ahar)

9/22/97 -- Received Amended Answer (placed on left side of file) (ahar)

10/10/97 13 ORDER allowing defts' to file an amended answer (signed by Judge Richard L. Williams) Copies Mailed: y (snea)

10/10/97 14 PRETRIAL ORDER filed Trial date 9:30 12/17/97 (signed by Judge Richard L. Williams) Copies Mailed: y (snea)

10/10/97 -- Pre-Trial Conference held (snea)

11/7/97 -- Deadline updated; RESET Bench Trial for 9:30 l/22/98 9 30 l/22/98 (jpea)

12/12/97 15 MOTION by Luciano Montalvo for Summary Judgment (adoh)

12/12/97 16 MEMORANDUM by Luciano Montalvo in support of [15-l] motion by Luciano Montalvo for Summary Judgment w/exhibits attached (adoh)

12/23/97 17 RESPONSE by James P. Radcliffe II, Southside Virginia to [15-l] motion by Luciano Montalvo for Summary Judgment (ahar) [Entry date 12/24/97] [Edit date 12/24/97]

12/23/97 17 MOTION by Southside Virginia, James P. Radcliffe II for Summary Judgment (ahar) [Entry date 12/24/971 [Edit date 12/24/971

12/23/97 18 MEMORANDUM by James P. Radcliffe II, Southside Virginia in support of [17-l] response to motion for summary judgment by Southside Virginia, James P. Radcliffe II (ahar) [Entry date 12/24/97]

12/30/97 19 Witness list by Luciano Montalvo (ahar)

12/30/97 20 Exhibit list by Luciano Montalvo (ahar)

1/15/98 21 Discovery Designation/Pre-Trial Disclosures filed by James P. Radcliffe II, Southside Virginia, Donna Radcliffe (adoh) [Entry date 01/16/98]

1/15/98 22 Exhibit list by James P. Radcliffe II, Southside Virginia, Donna Radcliffe (adoh) [Entry date 01/16/98]

1/15/98 23 Witness list by James P. Radcliffe II, Southside Virginia, Donna Radcliffe (adoh) [Entry date 01/16/98]

1/15/98 -- Exhibits received by James P. Radcliffe II, Southside Virginia, Donna Radcliffe (Blue plastic folder/2 sets) (adoh) [Entry date 01/16/98]

1/16/98 24 Stipulations filed by Luciano Montalvo, James P. Radcliffe II, Southside Virginia, Donna Radcliffe (adoh)

1/16/98 25 PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW by Luciano Montalvo (adoh)

1/16/98 -- Exhibits received by Luciano.Montalvo (white binder/2 sets) (adoh)

1/16/98 26 PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW by James P. Radcliffe II, Southside Virginia, Donna Radcliffe (adoh)

1/21/98 27 ORDER denying [17-1] cross motion by Southside Virginia, James P. Radcliffe II for Summary Judgment, denying [15-1] cross motion by Luciano Montalvo for Summary Judgment. Case will proceed to trial 1/22/98 (signed by Judge Richard L. Williams) Copies Mailed: yes (ahar)

1/22/98 28 Minute entry: IN OPEN COURT: Williams, J., Joseph Spontarelli, Chandler & Halasz Court Reporters. Parties w/counsel. Matter came on for Trial on Merits. Opening statements had. Pltf adduced evidence. Rested. Defts moved to dismiss any claims against the Defts in their individual capacity. Court granted same. Defts adduced evidence. Rested. Rebuttal evidence adduced. Evidence concluded.Arguments had. Matter taken under advisement by the Court. Order to enter.(1 hr., 35 mins.) (jpea)

1/22/98 -- Bench trial held (jpea)

1/22/98 29 MOTION by Donna Radcliffe, Southside Virginia, James P.Radcliffe II to introduce the deposition of Carey Savitch, M.D. (adoh) [Entry date 01/29/98]

1/26/98 34 Curriculum Vitae filed by Luciano Montalvo per direction in open court. (adoh) [Entry date 01/29/98]

1/29/98 30 ORDER that the deposition of Carey Savitch, M.D. shall be admitted into evidence (signed by Judge Richard L.Williams) Copies Mailed: y (adoh)

1/29/98 31 DEPOSITION of Carey Bruce on 01/09/98 (adoh)

1/29/98 32 FINDINGS OF FACT AND CONCLUSIONS OF LAW (signed by Judge Richard L. Williams 1 Copies Mailed: y (adoh)

1/29/98 33 FINAL ORDER that the case is dismissed with prejudice as to all defendants (signed by Judge Richard L. Williams) Copies Mailed: y (adoh)

1/29/98 -- Case closed (adoh)

2/5/98 35 NOTICE OF APPEAL by Luciano Montalvo. FILING FEE $105.00 RECEIPT # 30045708 TPO package given to counsel. (adoh) [Entry date 02/06/98]

2/10/98 -- USCA Case Number Re: CASE MANAGER: Carina Domeika USCA NUMBER: 98-1169 (adoh) [Entry date 02/11/98]

Docket as of February 17, 1998 1:51 pm

UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF VIRGINIA

Luciano Montalvo individually
and as the parent and
guardian of
Michael Montalvo
2796 Deer Run Drive
Petersburg, VA 23805
Plaintiffs

v. CASE NO.: 3:97CV487

James P. Radcliffe II
400C Southpark Blvd.
Colonial Heights, VA 23834

and

Southside Virginia Police
Karate Association, Inc. d/b/a
U.S.A. Bushidokan
400C Southpark Blvd.
Colonial Heights, VA 23834
Defendants

COMPLAINT

I. JURISDICTION

1. This Court has subject matter jurisdiction pursuant to 28 U.S.C. Section 1331 for claims arising under the Americans with Disabilities Act (ADA), 42 U.S.C. Section 42 USC 12101 et. seq. There is an actual controversy between Plaintiffs and Defendants.

II. VENUE

2. Pursuant to 28 U.S.C. Section 1391(b) venue is proper in this Court in that the events and omissions giving rise to the claims herein arose in the City of Colonial Heights, Virginia. Defendants' place of business is in the City of Colonial Heights, Virginia which is in the geographical area of this Court.

III. PARTIES

3. Luciano Montalvo is the parent and natural guardian of Michael Montalvo an eleven-year-old child. Plaintiff, Luciano Montalvo contracted with U.S.A. Bushidokan and Defendant, James P. Radcliffe II as School Manager/Owner for an unlimited membership plan for his son Michael Montalvo to participate in instructional classes, training sessions, demonstrations, seminars and competitions conducted held or sponsored by Defendants. Plaintiffs are residents of the City of Petersburg, Virginia.

4. Defendant, James P. Radcliffe II is an individual who as School Manager/Owner signed the agreement with Plaintiff, Luciano Montalvo. James P. Radcliffe II is the sole stockholder and president of Southside Virginia Police Karate Association, Inc., a Virginia corporation, d/b/a U.S.A. Bushidokan at 400C Southpark Blvd., Colonial Heights, VA 23834. U.S.A.

Bushidokan is a school for the instruction of the martial arts at 400C Southpark Blvd., in the City of Colonial Heights, VA 23834.

IV. FACTS

5. U.S.A. Bushidokan is a place of entertainment and recreation which is a "gymnasium . . . or other place of exercise or recreation" and thus is a public accommodation covered by the ADA, 42 U.S.C. Section 12181(L).

6. On May 3, 1997, Plaintiff, Luciano Montalvo and Defendant, James P. Radcliffe II as School Manager/Owner entered into an agreement for an unlimited membership plan for Plaintiff, Michael Montalvo to participate in instructional classes, training sessions, demonstrations, seminars and competitions conducted held or sponsored by U.S.A. Bushidokan.

7. Defendants arbitrarily and unlawfully have discriminated against Plaintiff, Michael Montalvo by denying Plaintiff, Michael Montalvo the full and equal access to and enjoyment of martial arts training services and facilities provided by Defendants because Defendants believe Plaintiff, Michael Montalvo may have Acquired Immunodeficiency Syndrome ("AIDS") or may be infected with the Human Immunodeficiency Syndrome ("HIV").

8. Defendants arbitrarily and unlawfully have discriminated against Plaintiff, Luciano Montalvo by denying to him as a parent the opportunity to provide for his son the enjoyment of martial arts training services and facilities provided by Defendants, solely because Plaintiff, Michael Montalvo may have AIDS or may be infected with HIV.

9. An individual who has or who is perceived to have AIDS or is infected with the HIV is a "qualified individual with a disability" within the meaning of 42 U.S.C. Section 12111(8).

V. FIRST CAUSE OF ACTION
(Violation of the ADA 42
U.S.C. Section 12182(b)(2) (A))

10. Defendants believe Plaintiff, Michael Montalvo is infected with the HIV or has been diagnosed with AIDS. Defendants individually and through counsel, on the basis that Plaintiff, Michael Montalvo is infected with the HIV or has been diagnosed with AIDS refused to provide Plaintiff, Michael Montalvo the full and equal access to and enjoyment of martial arts training services and facilities provided by Defendants and to honor the terms of the Membership Application and Agreement between Plaintiff, Luciano Montalvo and Defendants.

11. ADA prohibits discrimination on the basis of disability in the full and equal enjoyment of goods, services, facilities, privileges, advantages, and accommodations of any place of public accommodation by any person who owns, leases or leases to, or operates a place of public accommodation, 42 U.S.C. Section 12182 (b) (2).

VI. SECOND CAUSE OF ACTION
(Violation of the Virginia Persons with Disabilities Act,
Section 55.5-44B, Code of Virginia)

12. Plaintiffs reallege and incorporate herein by reference each and every allegation contained in paragraphs 1 through 11 above.

13. Section 55.1-44B, Code of Virginia, (the "Act") provides a "person with a disability is entitled to full and equal accommodations, advantages, facilities, and privileges of all . . . places of public accommodation, amusement or resort, and other places to which the general public is invited subject only to the conditions and limitations established by law and applicable alike to all persons."

14. At all times mentioned herein, Defendants' place of business, U.S.A. Bushidokan is a school for martial arts training services and facilities a "place of public accommodation" within the meaning of the Virginia Persons with Disabilities Act, Section 55.5-44B, Code of Virginia.

15. Through the conduct described above, Defendants have denied Plaintiffs the full and equal enjoyment of Defendants' "full and equal accommodations, advantages, facilities, and privileges " by arbitrarily and unlawfully discriminating against Plaintiffs because Defendants believe Plaintiff, Michael Montalvo may have AIDS or may be infected with the HIV and by denying Plaintiff, Luciano Montalvo the full and equal access for him as a parent to provide for his son the enjoyment of martial arts training services and facilities provided by Defendants, solely because Plaintiff, Michael Montalvo may have AIDS or may be infected with HIV.

16. Defendants' practices are discriminatory per se because they treat Plaintiff, Michael Montalvo as an outcast, based solely on his disability.

17. Plaintiffs are informed and believe, and on that basis allege, that Defendants are and at all times herein relevant have been engaged in conduct resistant to Plaintiffs' full enjoyment of rights guaranteed them by the Act.

18. To prevent Defendants from continuing to violate the Act, Defendants should be enjoined and prohibited from the unlawful and invidious discriminatory practice of failing or refusing to provide services, and access to Defendants' facilities to persons who have or are perceived to have AIDS or who are or are perceived to be HIV-infected. Defendants should be further ordered to take all steps necessary to ensure the full enjoyment of all rights guaranteed under the Act. Plaintiffs are entitled to such injunctive relief under the Virginia Persons with Disabilities Act, Section 55.5-46A, Code of Virginia.

19. As a direct and proximate result of Defendants' discriminatory practices, Plaintiffs have suffered actual damages in the form of shame, humiliation, degradation, and emotional distress in an amount to be determined at trial. Pursuant to Virginia Persons with Disabilities Act, Section 55.5-46A, Code of Virginia. Plaintiffs are entitled to actual damages in an amount to be determined at trial.

20. In committing the acts described above, Defendants acted maliciously and oppressively with a conscious, reckless, willful, and callous disregard of Plaintiff's rights, and with the intent of depriving him of rights guaranteed by the Act.

VII. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment as follows:

1. For injunctive relief ordering Defendants to:

a. enjoin Defendants from continuing to engage in their unjustifiable practice of denying Plaintiffs access to and the use, benefit and enjoyment of martial arts training services and facilities provided by Defendants, based wholly or partly on the

fact that the Plaintiff, Michael Montalvo has or may have AIDS or is or may be HIV infected.

b. refrain from discriminating in any manner, by failing or refusing to extend to any individual who has or is regarded as having AIDS or who is or is regarded as being infected with HIV, the full and equal enjoyment of and access to Defendants' services and facilities of any kind whatsoever, on the basis (either in whole or in part) of the fact or perception that such individual has AIDS or an AIDS-related condition, or is infected with HIV;

c. train and educate each and every individual staff member, and all other personnel employed or associated with Defendants' facilities, regarding the actual risks of AIDS or HIV-infection and the precautionary measures which must or should be taken to prevent transmission of the disease, including but not limited to the use of universal precautions;

d. train and educate each and every individual staff member, and all other personnel to maintain the confidentiality of Plaintiff's and potential customers' medical and health information, and to disclose such information only as and to the extent necessary for that customers' medical treatment or care, and only to such persons as are necessary to ensure the customer full and competent medical care and treatment.

2. For an award of compensatory damages to Plaintiffs equal to the injury each has suffered due to Defendants' discriminatory practices, in an amount to be determined at trial.

3. For an order awarding Plaintiffs their costs of suit, including litigation expenses, out-of-pocket expenses, and reasonable attorneys' fees, in accordance with all applicable

provisions of law including 42 U.S.C. Section 12188 and Virginia Persons with Disabilities Act, Section 55.5-46A, Code of Virginia.

4. For such other and further relief as the Court may deem just and proper.

/s/ Terry W. Raney
Terry W. Raney, Esq.
Suite 1
8154 Forest Hill Avenue
Richmond, VA 23235
804-272-5994
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Virginia State Bar Identification # 34107

Attorney for Luciano Montalvo individually and as the parent and guardian of Michael Montalvo

UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF VIRGINIA

Luciano Montalvo et al,

Plaintiffs

V. Civ. NO .: 3:97CV487

James P. Radcliffe II et al

Defendants

STIPULATIONS OF FACT

Plaintiffs, Luciano Montalvo et al and Defendants, James P. Radcliffe II et al, respectfully stipulate to the following facts:

Admission of Facts:

1. Defendants' place of business is in the City of Colonial Heights, Virginia which is in the geographical area of this Court.

2. Luciano Montalvo is the parent and natural guardian of Michael Montalvo an eleven-year-old child.

3. The writing, attached Exhibit A, between Plaintiff, Luciano Montalvo and Defendants James P. Radcliffe II and Southside Virginia Police Karate Association, Inc. d/b/a U.S.A. Bushidokan and Donna Radcliffe was signed by Donna Radcliffe as School Manager/Owner of Southside Virginia

Police Karate Association, Inc. d/b/a U.S.A. Bushidokan.

4. Defendant, James P. Radcliffe II is an individual who is the sole stockholder and president of Southside Virginia Police Karate Association, Inc., a Virginia corporation, d/b/a U.S.A. Bushidokan doing business in Colonial Heights, VA 23834.

5. U.S.A. Bushidokan is a school for the instruction of the martial arts in the City of Colonial Heights, VA 23834.

6. U.S.A. Bushidokan is a place of entertainment and recreation which is a "gymnasium . . . or other place of exercise or recreation" and thus is a public accommodation covered by the ADA, 42 U.S.C. Section 12181(L) and under the Virginia Persons with Disabilities Act, Section 51.5-44, Code of Virginia.

7. Defendants would not allow Plaintiff, Michael Montalvo to participate in the martial arts training classes provided by Defendants because Defendants believe Plaintiff, Michael Montalvo is infected with the Human Immunodeficiency Virus ("HIV") or has Acquired Immunodeficiency Syndrome ("AIDS").

8. Defendants offered to allow Plaintiff Michael Montalvo to have private lessons.

/S/ Terry W. Raney
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804-272-5994
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Virginia State Bar Identification # 34107

/S/ Nathaniel M. Collier, II
Attorney for James P. Radcliffe II et al
Nathaniel M. Collier, III
Attorney for James P. Radcliffe II et al
200 Lakeview Avenue
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804-520-2319
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AFFIDAVIT

State of Virginia
County/City of Richmond

I, Suzanne R. Lavoie after being duly sworn deposed and state:

I am a medical doctor duly licensed and practicing in the State of Virginia. I am a treating physician for Michael Montalvo and I am thoroughly familiar with his physical condition. I have recently examined Michael Montalvo and find him fit to begin karate classes.

/S/ Suzanne R. Lavoie, M.D.
Suzanne R. Lavoie

Sworn to and subscribed to by Suzanne R. Lavoie before me a Notary Public this 26 day of June, 1997

(Signed) _____
My commission expires: Commission Expires May 31, 1999.

IN THE UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF VIRGINIA
Richmond Division

LUCIANO MONTALVO, et al.,

Plaintiffs,

v.

Case No. 3:97CV487
NOTES OF
TESTIMONY

JAMES P. RADCLIFFE, II,
et al.,

Defendants.

Before: HON. RICHARD L. WILLIAMS, JUDGE

January 22, 1998

Richmond, Virginia

PROCEEDINGS

THE CLERK: Civil action Number 3:97CV487, Luciano Montalvo individually and as the parent and guardian of Michael Montalvo versus James P. Radcliffe, II and Southside Virginia Police Karate Association, Inc. Mr. Terry Raney represents the plaintiffs and Mr. Nathaniel M. Collier, III represents the defendants.Are counsel ready to proceed?

MR. RANEY: Plaintiff is ready, ma'am.

MR. COLLIER: Defense is ready.

(Opening statements presented on behalf of the plaintiffs and on behalf of the defendants.)

THE COURT: Thank you.Call your first witness.

MR. RANEY: Dr. Suzanne Lavoie.

Your Honor, as an accommodation to Dr. Lavoie Mr. Collier and I have agreed to call Dr. Lavoie first and get her testimony and cross so she can get back to work. Does Your Honor have any objection to this accommodation?

THE COURT: None at all.

MR. RANEY: Thank you, sir.

SUZANNE R. LAVOIE, M.D., was sworn or affirmed and testified as follows:

THE COURT: Do you have a copy of her curriculum vitae?

MR. RANEY: No, sir, I don't.

THE COURT: Do you stipulate to her qualifications?

MR. COLLIER: Yes, sir.

THE COURT: Fine. Get a copy of her curriculum vitae and file it as an exhibit. I'll rule that she qualifies as an expert.

DIRECT EXAMINATION

BY MR. RANEY:

Q Dr. Lavoie, describe your relationship with Michael Montalvo, please.

A I have been Michael Montalvo's physician for approximately four years now.

Q As his physician have you diagnosed an infectious condition in Michael, and if so, what is that condition?

A Michael has Acquired Immunodeficiency Syndrome. I didn't diagnose him with that. When I started taking care of him he had the diagnosis of the human immunodeficiency virus infection. Subsequent to that he developed the syndrome which made him have Acquired Immunodeficiency Syndrome.

Q Is it your medical judgment right now that Michael has AIDS?

A Yes, sir.

Q Mr. Luciano Montalvo, Michael's father, did Mr. Montalvo discuss with you Michael's participation in a karate class, and if so, tell Judge Williams what that discussion was, please?

A Mr. Montalvo approached me one day at the clinic stating that Michael had some friends who were participating in a karate class. He asked my opinion about Michael's participation in karate. My feelings at the time were that Michael's health was good; that he was an active, ordinary 12-year-old and that he would be able to physically participate in such a class.

Q Dr. Lavoie, as a physician working in infectious diseases did you consider the possibility that Michael could transmit his disease to others, and if so, tell Judge Williams what your considerations were?

A As a physician working in infectious diseases with patients with Acquired Immunodeficiency Syndrome we consider the known causes of transmission of that virus when people request information about participation. Based on the known ways of transmission of this virus I felt that participation in karate would not pose a risk either to Michael or to other people in the class.

Q Tell Judge Williams what are the known ways of transmission for the HIV virus.

A Transmission of HIV occurs through the transmission of infected cells in either blood or sexual secretions, so the known causes of transmission are either blood transfer through sharing of needles or sharing of blood in some other way and through sexual activity.

Q In regard to when a person is injured and may be bleeding, describe for Judge Williams what the proper and appropriate medical precautions are to deal with that person.

A When you talk about any infectious disease that is transmitted by blood or body fluids there is a method of decreasing the risk of transmission called universal precautions. Those precautions make recommendations about barriers that can be used if there is visible blood or body secretions and various types of barriers that are to be used for different types of exposures.

Q Do you have any medical judgment concerning a probability or percentage of risk factor of Michael if he were bleeding and the possibility that another individual would contract the HIV virus from Michael, an if so, tell Judge Williams what that opinion is?

MR. COLLIER: Your Honor, I'm going to object at this point. I'm not sure that's a proper hypothetical. Under what circumstance --

THE COURT: There are so many variables that an answer to this question wouldn't be very probative, would it?

Suppose he has an open wound excreting blood and the person that he's grappling with has an open wound and their blood gets mixed, I take it that would be a means of transmission?

THE WITNESS: Potentially.

THE COURT: There are so many variables that any answer would not be probative of anything.

BY MR. RANEY:

Q Given Judge Williams' comments about Michael with an open wound and bleeding and some other individual with an open wound and bleeding, what would be the medical scenario for transmission of the HIV virus?

A I'm not sure I understand the question. I think that there is no documented knowledge about the exact risk of transmission in such a situation. We have information about things that could potentially increase the risk of transmission. If I talked about the particular instance where Michael had an open wound and was bleeding and another person had an open wound and was bleeding, I think that there is a potential for transmission in that case. I couldn't tell you an exact percentage or what the risk of transmission would be. I think that it would be small but I think there is a potential risk of transmission.

Q As far as your medical information and knowledge is concerned, is there any scenario or study that has examined the situation that has just been described to you?

A As far as I know there is no such study.

Q Are you aware of any antidotal information concerning that scenario and whether or not transmission has taken place?

A I'm not aware of any antidotal or documented cases of transmission in such a scenario.

Q Dr. Lavoie, in the exhibit book in front of you or to the side there, number two in there -- would you look at that document and if you can identify it and tell Judge Williams what that document is, please.

A It's an Affidavit signed by me stating that I'm a medical physician licensed to practice in the State of Virginia, and I'm familiar with his medical condition and I felt that he was fit to be in karate classes.

Q Describe for Judge Williams, please, the circumstances that brought you to prepare this document, please, or sign the document.

A I was, as I said, approached by Mr. Montalvo who asked me if I felt that Michael could participate in karate classes. I told him that I believe that Michael was fit to do so. Shortly thereafter he contacted me stating that he had been informed by the karate school that Michael was not going to be able to take karate lessons because of his HIV infection. He asked me to write a letter stating that I felt Michael's health was such that he could take karate lessons. That there was some discussion with the karate school that in order for Michael to take lessons he needed a letter such as that so therefore I prepared the letter.

Q It was your medical judgment --

THE COURT: The circumstances of the Affidavit isn't particularly probative of any issue. The document speaks for itself, doesn't it?

MR. RANEY: Yes, sir.

THE COURT: Fine.

BY MR. RANEY:

Q Dr. Lavoie, you mentioned earlier in your testimony the means of --

THE COURT: If she did I heard it. I pay very close attention. Don't have her repeat what I already heard. You said you mentioned earlier and I heard it. Believe me, I pay very close attention so you want to move things.

MR. RANEY: I believe you.

THE COURT: All right.

BY MR. RANEY:

Q Dr. Lavoie, did Donna Radcliffe or James Radcliffe or anyone from U.S.A. Bushidokan contact you in regard to Michael Montalvo, and if so what was that contact?

A I don't remember exactly who contacted me. I believe it was the lawyer for the karate school who contacted me about this issue and asked me some questions very shortly after I had written this l e t t e r . At that time I did not have any signed release of medical records from Michael's father and I could not discuss the case with him when I got that telephone call.

Q Dr. Lavoie, in your medical judgment if universal precautions are practiced in a contact sport, what is the risk of transmittal of infection from an HIV positive person to a non-HIV positive person?

MR. COLLIER: Your Honor, again I'm going to object.

THE COURT: And again I'll sustain the objection because there are so many variables that any answer would be basically meaningless.

MR. RANEY: Yes, sir.

BY MR. RANEY:

Q Is there a particular medical recommendation that you have for an HIV positive person who is bleeding who comes in contact with an open wound of a non-infected person, and if so what is that recommendation?

MR. COLLIER: I'm going to object to the relevance, Your Honor.

THE COURT: Go ahead and answer the question. Counsel, you pretty well established with this witness everything that is really probative in the case, haven't you?

MR. RANEY: Sir, if you would just indulge me for this one question.

THE COURT: I will.

MR. RANEY: Thank you.

BY MR. RANEY:

Q Ma'am?

A I think there are recommendations for all interactions including for children in school or people in both amateur and professional sports that if there is contact with visible blood universal precautions should be used. Persons who are cleaning up the blood or involved in it should wear gloves, the bleeding wound should be covered as soon as possible so that there is minimal exposure. There are recommendations about how to cleanup areas where there has been visible bloodshed.

MR. RANEY: Dr. Lavoie, thank you for your testimony. Please answer Mr. Collier's questions.

THE COURT: Any cross-examination?

MR. COLLIER: Yes, sir, Your Honor.

CROSS-EXAMINATION BY MR. COLLIER:

Q Dr. Lavoie, it's fair to say that the primary causes of transmission of HIV would be from sharing of blood through such things as IV drug usage, sexual encounters, transfusions, things of that nature, is that correct?

A That's correct.

Q But there are others ways, are there not, that HIV is transmitted?

A I'm not sure what you're referring to.

Q Let me ask you some specific questions. First of all, are you aware of any cases that have been reported that involved the transmission of HIV which did not involve sexual encounters of the use of an IV needle?

A Yes.

Q Could you describe what those would be?

A There are one or two cases of transmission between household members particularly traced to transmission

from combined use of equipment like tooth brushes or other household items that were visibly stained with blood, so the proposed transmission was through blood transmission.

Q Let me ask you about that. You say that the tooth brush was visibly stained with blood.

THE COURT: Counsel, don't waste my time on this sort of thing. She's testified that there are other ways that you can do it. That pretty well burns the subject out, doesn't it?

MR. COLLIER: Yes, Your Honor.

THE COURT: All of us read the paper about blood transfusions and things of that nature. Arthur Ashe, for instance, wasn't he a victim of blood transfusion? Don't waste my time.

MR. COLLIER: Thank you, Your Honor.

BY MR. COLLIER:

Q Are there situations in which the saliva of an individual can be contaminated with blood from that same individual?

A Yes.

Q Can that occur through, for instance, the brushing of teeth?

A Yes.

Q Would you describe for the Court what a virion is an what a virion means in terms of transmission of HIV?

A A virion is one HIV particle. In order to have transmission you need intact capable of replication HIV virions.

Q How many does it take to transmit HIV?

A I don't believe that's known.

Q You don't know, so as far as you know it may just take one?

A I can't answer that question.

Q You just don't know?

A Correct.

Q Are these virions present in a normal person's saliva, a person who is HIV infected without the introduction of

blood?

A They may be present. If they are present they are in very low numbers.

THE COURT: Doctor, is Michael capable of engaging in the normal activities a 12-year-old would engage in?

THE WITNESS: Yes, he is.

BY MR. COLLIER:

Q If blood is introduced into the saliva, again we're dealing with an HIV positive person, is it more likely that the number of virions increases at that point?

A The number of virions would increase if there was visible blood in the saliva, yes.

Q Would it be possible if someone were struck in the facial area that the agitation involved in being struck in the facial area by a fist, for instance, would it be possible that blood would be spilled into the saliva in that scenario?

A It's possible that someone could get a bloody mouth from being punched in the face, yes.

Q And if that person were wearing, for instance, a mouthpiece which fits up into the gums and that person were punched in the face, would it be likely that the agitation of that mouthpiece rubbing up against the gums might also introduced some blood into the saliva?

A That would be possible.

Q Are you familiar with Dr. David Acer, a dentist in Florida? Are you familiar with his case?

A Yes.

Q Are you familiar with the fact that five of his patients -- at least five of his patients -- were infected with the HIV virus from Dr. Acer?

A There have been cases, at least five, that have been traced with reasonable certainty to the virus, yes.

Q Isn't there a certain RNA pattern that allows you to detect whether the virus that you have acquired has come

from another specific individual?

A I don't think there is a simple test to do that.

Q I didn't ask you if there was a simple test.

A There are tests that can tell you that it's very likely that it came from that same person, but there is no test that 'can tell you with absolute certainty that it came from that person.

Q You are aware through the medical literature that the HIV virus that was acquired by Georg Orgalis and by the other individuals had the same RNA pattern as that of Dr. Acer, are you not?

A It was very close to Dr. Acer's pattern, yes.

Q Were there any other known causes which you described as the primary transmitters of the Virus such as sexual contact between Dr. Acer and these individuals?

A There was no other known transmission factors in those patients.

Q Other than the contact with dental instruments that ostensibly had been sterilized at different points, there's no other contact there, is there?

A Correct. I think what we don't know about that case is how effectively those instruments were sterilized or what kinds of precautions were used with those instruments.

Q Let's talk about universal precautions real quickly. I believe you testified --

THE COURT: Counsel, she did. I heard it. I pay very close attention. Don't repeat what she said. Ask her questions.

MR. COLLIER: Yes, sir.

BY MR. COLLIER:

Q Do you recall testifying in a deposition that universal precautions in a setting of -- to put it in laymen's terms -- fist fight scenario could not be used effectively to prevent the instantaneous transmission of blood?

A I believe in a fist fight-type of scenario you

could not prevent instantaneous blood exposures.

Q If I give you a hypothetical that there are two individuals --

THE COURT: Counsel, universal precautions -- if he's having a confrontation each of them would have to take universal precautions, would they not?

THE WITNESS: That's correct.

THE COURT: That's common sense. Don't waste my time on the obvious.

MR. COLLIER: Judge, if I could address the Court --

THE COURT: She just made your point. Whoever is engaged in a confrontation with him, they would have to take universal precautions.

BY MR. COLLIER:

Q Could you describe how universal precautions could be used by an individual in the setting that I have described to you, two individuals in a fist fight scenario?

A Universal precautions are designed to take into account the possibility of transmission of any infections. On that basis they are designed to be used before situations occur and after situations occur. They are not only for after situations occur. I think the difficulty with the situation you're talking about is that people would not be taking into account what might happen on the basis of a spontaneous fist fight.

Q Could you describe for the Court how universal precautions could be applied in a situation that I'm going to give you a hypothetical on in order to address this -- two individuals are fighting, one who is HIV positive strikes the other in the facial area, the person who is not HIV positive cuts his hand on the mouth of the individual who is, following that strike there is a wrestling move designed to take that individual down to the floor so that they stay in contact with one another --

THE COURT: Mr. Collier, hypothetical questions have basically been abolished in the federal system. Move on to

something. Don't waste my time because there are so many variables in the scenarios that one hypothetical doesn't do any good. It isn't probative of anything. Move on to something else.

MR. COLLIER: Thank you, Your Honor.

BY MR. COLLIER:

Q Is it possible to assure with universal precautions that the blood from one combatant wouldn't be spilled into the other if they maintained contact with one another and there is an open wound with each individual?

A I think maintaining contact in the setting of visible blood would not be using universal I precautions.

Q If blood from one individual was spilled into the open wound of another, can that transmit HIV?

A I think I have already said there's a potential for that.

THE COURT: Does that conclude your examination?

MR. COLLIER: No, sir, Your Honor.

THE COURT: The purpose of cross-examination is to produce evidence that's probative of some issue. I will have to make specific Findings of Fact on it and I can't think of anything else the Dr. Lavoie will say that will enable me to make Rule 52 findings that I have to make. Now that I have made that suggestion, you have any further questions?

MR. COLLIER: Just one, Your Honor.

THE COURT: All right.

BY MR. COLLIER:

Q Under universal precautions are surgeons required or do surgeons in fact cover the eye area when they perform surgery?

A I believe that they do, yes.

Q Why?

A For the potential of splash of blood.

Q What is the danger of splashing of blood?

A There is potential for blood to have contact with

open mucus membranes like the mucus membranes of the eye.

Q That would be similar in terms if someone had acne or had some other skin irritation, there would be a possibility of blood entering those?

A I think the cornea is a particularly porus membrane and that has special recommendations with regards to universal precautions. I don't believe that there are any recommendations for covering up acne in order to prevent the splash of blood onto that.

THE COURT: May Dr. Lavoie be excused?

MR. COLLIER: Yes, Your Honor. Thank you.

THE COURT: Dr. Lavoie, thank you for being with us. You're now free to go. Call your next witness.

MR. RANEY: Mr. Montalvo.

LUCIANO MONTALVO, was sworn or affirmed and testified as follows:

DIRECT EXAMINATION

BY MR. RANEY:

Q Mr. Montalvo, you are the plaintiff in this case and the father of Michael Montalvo who is also a plaintiff in this case, is that correct?

A Yes, sir.

Q Let me take you back to May of 1997. Tell Judge Williams what contact you had with U.S.A. Bushidokan and what happened?

A I went in there to sign my son up for karate. We filled out the application, my wife and I, and we handed it to Miss Radcliffe. I don't believe I spoke with Mr. Radcliffe, I just filled out the application. We bought the uniform and everything then we left.

Q Take a look at Plaintiff's Exhibit No. 1 in the white book if you would, please. Is that the document that you just referred to?

A Yes, it is.

Q You signed it and Miss Donna Radcliffe signed it?

A Yes.

THE COURT: What was the date this was filed?

THE WITNESS: May 3, '97, Your Honor.

THE COURT: Thank you.

BY MR. RANEY:

Q Mr. Montalvo, describe for Judge Williams what your next contact was with U.S.A. Bushidokan.

A Approximately 20 minutes later when I got

home I got a phone call and it was Mr. Radcliffe. He said I received some information. I understand your son has AIDS. I said, that's not true and I hung up the phone.

Q Then what happened next?

A I called my son's friend's mother down the block and I asked her if she had told Mr. Radcliffe that Michael had AIDS and she said no.

MR. COLLIER: 1'11 object to hearsay, Judge.

THE COURT: Proceed. The objection is overruled.

BY MR. RANEY

Q What was your next contact with U.S.A. Bushidokan? Tell Judge Williams about that.

A My next contact was after I had got the letter from Dr. Lavoie and I brought it in to U.S.A. Bushidokan and showed it to Mr. Radcliffe.

Q What is it that caused you to talk with Dr. Lavoie about Michael's medical condition?

A I wanted to know if I would be able to sign Michael up without any problems, that's why I talked to her. I asked her if it would be okay. If she would have said no, that wouldn't be a good idea I probably wouldn't have did it. She said that sounds like a good idea, I think he'll really like that. I was just worried am I required to tell them that he's HIV positive like I wasn't required to tell the school. Do they need to know? That's what I needed to know from her. She said no, I don't believe they need to know.

Q Dr. Lavoie told you that?

A Yes. .

Q Take a look at Plaintiff's Exhibit 2 and tell us is that the statement that you obtained from Dr. Lavoie?

THE COURT: It's cumulative. She testified to it. It's set in concrete.

BY MR. RANEY:

Q Is this the statement you provided U.S.A.

Bushidokan?

A Yes, it is.

Q When was the next contact you and Michael had with U.S.A. Bushidokan? Tell Judge Williams about that.

A After I gave Mr. Radcliffe the letter I said, is that sufficient, is it okay, can Michael participate tonight because I did show up there with my son and his Gi and he said yes, there's no problem. Michael participated that night. The next morning or the next afternoon I got a phone call from Mr. Radcliffe again saying he spoke to his lawyer, Mr. Collier, and that letter wasn't sufficient, he needed an AIDS test. That's when I told him he is HIV positive and what are you going to do now. He participate.

THE COURT: What was the date of that, Mr. Montalvo?

THE WITNESS: I don't know the exact day. It was maybe 10 days after. It was like a day after I got the letter from Dr. Lavoie so about maybe 10 days after May 3rd, about the second week of May.

THE COURT: Her letter was executed on June 26th it appears. Would it have been in July?

THE WITNESS: Yes. I got the dates mixed up. It took a while for me to get the letter from Dr. Lavoie to Mr. Radcliffe.

BY MR. RANEY:

Q After Mr. Radcliffe called you and said that Michael could not participate despite having the information from Dr. Lavoie, tell Judge Williams what happened next involving you, Michael and U.S.A. Bushidokan.

A Well, I went in there and I talked to Mr. Radcliffe in reference to this. He was telling me that the reason why he wouldn't be able to participate is because he was worried about the risk of the other children. That's when I spoke with him in reference to that. I asked him what do you

do if, if let's say, there's a situation and two boys were sparring and one of them started to bleed. He said, we stop right there and we pull them out of the class and take care of it. I was like well, what happens if somebody walks in there and they have open wounds on their body or poison ivy and he said they can't participate until it's cleared up. In other words, you wouldn't let anybody participate if they have any open wounds? He said, that's correct. If an open wound occurs we pull them out of class and we take care of it. I was like, okay.

Q Did either Mr. Radcliffe or Mrs. Radcliffe offer any suggestions to you as to how Michael could participate, and if so tell Judge Williams what those offers were?

A He offered me private classes for Michael. I told him that wouldn't be acceptable because the whole reason why I wanted to sign Michael up is for the self-defense classes that his friends were participating in. It would make no sense for him to go there alone; he wanted to be with his friends.

Q Let me take you back to the May 3rd contact with U.S.A. Bushidokan when you and Miss Montalvo are signing up Michael. Was any description given to you at this time by anybody about what the karate instruction involved and if so, what was that description?

A Mr. Radcliffe was basically telling me it was a -- giving me a little bit of the history of the karate and said that it was basically for self-defense and self-discipline, and that was two main reasons why I wanted to have him join. That's basically all we talked about was the self-defense and the history of the Bushidokan.

Q Mr. Montalvo, when was the first time anyone at U.S.A. Bushidokan, Mr. Radcliffe, Miss Radcliffe or anyone else brought to you information that this was hazardous, dangerous or there was potential injury involved? Tell Judge Williams when that first happened.

A It would be after I told him that yes, he was

HIV positive. I went in there and I talked to him about why he couldn't participate, is there any special reason why. After I spoke to him I just walked out. After he offered private classes I said no thank you, and I walked out.

MR. RANEY: I have no other additional questions. Please answer Mr. Collier's questions.

THE COURT: Any cross-examination?

MR. COLLIER: Yes, Your Honor.

BY MR. COLLIER:

Q Mr. Montalvo, when you signed the agreement which you see as Exhibit 1, were you aware of the provision in the agreement that said that Michael had no infectious diseases which could possibly be transmitted to another person?

A Yes, I read that part.

Q You have testified at some point in this process, have you not, that you are aware there are risks involved in handling blood -- I believe your own words were everybody in the world knows there are risks in handling infected blood of an HIV person, correct?

A Yes, I did.

Q Knowing that there are risks in simply handling the blood of someone who is HIV positive you signed this agreement under circumstances in which you were also aware of the provision that said he didn't have an infectious disease that could possibly be transmitted, is that correct?

A I signed that agreement knowing that. I didn't say anything to him about the HIV status, yes.

Q Part of the reason was because you didn't think Michael was going to be having sexual contact or sharing a needle with anybody, is that correct?

A I didn't think Michael would be able to participate if I did tell them. I was afraid he would kick Michael out of the class if I told him he was HIV positive.

Q Mr. Montalvo, you're on record as saying the

real danger in dealing with this is dealing with people you don't know have the disease?

A I said it.

Q You said it in an interview on TV, didn't you?

A Yes, I believe I did.

Q Yet you were going to put Michael in a situation without disclosing to Mr. Radcliffe that he was HIV positive?

A I still don't believe that he was infectious to others.

Q That's not the question I asked you.

A Could you repeat the question?

Q Knowing there is a risk of transmitting the disease and being on record as saying the real danger in dealing with this is dealing with people you don't know have the disease, you were willing to have him go in and participate in this karate instruction program without disclosing that to Mr. Radcliffe, were you not?

A Yes, I was.

Q Did you disclose it to Mr. Radcliffe when you brought the letter from the doctor?

A No, I didn't.

Q How many times did he have to ask you before you finely admitted that your son was HIV positive or that your son had AIDS?

A Once -- twice, that phone call I received on May 3rd.

Q You acknowledge that Mr. Radcliffe did offer to give you private lessons -- to give Michael private lessons?

A Yes, he did.

Q Did he explain to you the reasons why he didn't feel Michael's full participation in the program was wise?

A Say that again.

Q Did he explain why he didn't think Michael

should participate in the program fully?

A Yes, he explained it to me.

Q What did he tell you?

A He was, worried about the risk of others and that's why I asked him about if anybody started to bleed what would you do and he said we pull them out of the class. I asked him if anybody would be participating in the class if they had open wounds or poison ivy or anything and he said no. If the students had open wounds or got an open wound while participating that everything would be stopped right there and they would be pulled out of class until it was taken care of.

Q You signed the agreement when, May 2nd?

A No.

Q When did you sign the agreement?

A May 3rd.

Q I'm sorry. It wasn't until approximately July when you admitted to Mr. Radcliffe that Michael had AIDS or that Michael was HIV positive, is that correct?

A I don't remember the exact date but it was the day after he participated that night.

Q How many conversations do you think you had between signing the agreement and finally acknowledging in which Mr. Radcliffe asked you specifically whether or not Michael was HIV positive or whether or not he had AIDS?

A That was the only conversation. The second time I talked to him was after I brought him the letter.

Q The only conversation was when signed him up and --

A I didn't speak to him when I signed him up, I spoke to his wife.

Q You spoke with him that night, did you not?

A Yes. When I got home that's the time when I talked to him; that was the first time I talked to him.

Q Are you testifying under oath that there were no

further conversations between you and Mr. Radcliffe between that conversation and between the time that you spoke with him after Dr. Lavoie had written a letter?

A I can't remember if I did. I might have called him and my wife might have also called him to ask him why he wouldn't be able to participate which lead to getting the letter from Dr. Lavoie, I believe.

Q Mr. Montalvo, have you ever been convicted of a felony or a crime involving lying, cheating or stealing?

A Yes, I have. I have been convicted of a felony. Can --

Q That's the only question I asked.

A Can I finish, please?

MR. COLLIER: Judge, I asked him a yes or no question.

THE COURT: That's all you're entitled to. May the witness stand down?

MR. COLLIER: Yes, sir, Your Honor.

THE COURT: Thank you, Mr. Montalvo. You may return to your seat.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

LUCIANO MONTALVO, et al
Plaintiff,

vs. CIVIL ACTION NO.:

JAMES P. RADCLIFFE, II et al. 3:97CV487
Defendant.

The deposition of CAREY BRUCE SAVITCH, taken at the instance of the Defendant by agreement of counsel, before ANNETTE L. IMBRIACO, a Court Reporter and Notary Public for the State of Virginia at Large, on the 9th day of January, 1998, beginning at 5:00 p.m., at the office of Nathanial Collier, 200 Lakeview Avenue, Suite C, Colonial Heights, Virginia; said deposition taken pursuant to Rules of Civil Procedure for the United States District Courts.

APPEARANCES:

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INDEX

	DIRECT	CROSS
Cary Savitch	4	60

CAREY BRUCE SAVITCH, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. COLLIER:

Q Dr. Savitch, if you could, just for the record, state your full name.

A My first name is Carey, C-A-R-E-Y. My last name is Savitch, S-A-V-I-T-C-H. I am a medical doctor. My middle name is Bruce, if that is needed.

Q And would you state your address, where you are physically located right know? Where your office address would be?

A Right now, I am at 2929 Loma Vista Road, Suite F, Ventura, California 93003.

Q Okay. Before we get into the area of your practice, Dr. Savitch, what I would like for you to do is state your academic qualifications, starting with your college?

A I went to undergraduate at UCLA. I went to medical school at the University of California, San Francisco. I graduated there in 1973. I did two years of internship and residency at USCLA County. I then, did a year of residency at UC Davis, which was kind of combined with a year of infectious diseases.

Following that, I finished my infectious disease fellowship at the University of California, San Francisco, and

trained at the San Francisco General Hospital, this was in the years of '79 and '80. I have been in private practice since 1980 to the present. I have been Assistant Medical Professor of Medicine at. UCLA from 1982 to the present.

Q Okay. And in that regard, have you had any continuing education of note, since you finished your formal education in 1982?

A Just 8 million conferences and things like that. But no formal training program after I finished my infectious disease fellowship. I am board certified in internal medicine and in infectious diseases. I am a fellow of the American College of Physicians. I am a member of the Infectious Disease Association of California, and perhaps several other medical type societies.

Q Okay. And if you would just describe what percentage of your practice is devoted to infectious diseases?

A Probably about 90 percent infectious diseases.

Q Okay.

A And ten percent maybe general internal medicine.

Q Okay. What percentage of your practice is devoted to HIV and AIDS?

A About 20 percent of my practice.

Q Okay.

A It could be a little bit more at times.

Q Would you describe what your typical role is in the environment of HIV and AIDS. What kind of services you provide to your clients?

A I directly treat patients. Most of the patients are referred to me through a consultant. But basically, the monitoring and caring of patients with AIDS. I have been doing this since the beginning of the epidemic.

Q Okay.

A I also do a lot of education in schools, medical groups, nursing groups and civic groups. So, I do a lot of AIDS education, as well. I have probably given more AIDS lectures than any doctor I know in last two years.

Q Okay. Would you describe, in some sort of quantifiable terms, how many you have given over the last two years?

A How many lectures?

Q Yes.

A I have probably given two a week for the last year and a half. As well as doing various programs on radio and on television.

Q Okay.

A I also have written a book on AIDS.

Q Okay. And what is that book?

A The title of the book is: The Nutcracker is Already Dancing.

Q Okay. And have you also been involved in any congressional studies or congressional hearings?

A Yes. I gave a talk on Capitol Hill, to a group, including people from different congressional offices. It was an informal kind of hearing, and this was in, I think, September or October of this year.

Q Okay.

A And I am invited to go next week to do an assembly hearing in Sacramento. And I think that will be on Tuesday of next week that I will be going up there.

Q Okay.

A It will be on assembly bill, I think it is AB881. And this is a bill dealing with testing in children.

MR. COLLIER: Could we go off of the record for a second.

(Discussion held off the record.)

MR. COLLIER: Okay. We can go back on the record.

BY MR. COLLIER:

Q Doctor, are you familiar with the reason that we are here today? In order words, the action that is involved is a young child, Michael Montalvo, who is HIV positive by a diagnosis of his personal physician, Dr. Suzanne LaVoie, from the Medical College of Virginia. He has now been diagnosed as having AIDS. He has a couple of the symptoms, I guess you would say, that take us from HIV to AIDS.

He has applied to a karate instruction program in the City of Colonial Heights run by J. Radecliff, who is my client. This is what is called a hard style of karate, in which you have open combat from time to time. Sometimes --

MR. RANEY: I am going to object to the description. I don't think this has anything to do with the question. So, characterization of the karate activity is what I object to as not being necessary for the question. Unless you are attempting to pose a hypothetical, and I don't think you have laid the proper foundation, if that is what you are trying to do.

MR. COLLIER: Well, the objection is noted. Actually, what I am trying to do is make sure he is aware of the facts.

BY MR. COLLIER:

Q At any rate, Doctor, the evidence that has been given to the Court, in terms of depositions, is that part of the program involves hand to hand combat, sometimes with pads, sometimes without pads, in an environment where the spilling and transfer of blood would not be an uncommon thing?

A Right. I am aware from what I read, basically in the papers, that this was a karate class and that this young man had applied to be a student in the karate class. And

because of the combat and because of the potential for blood splashing and wounds, that he was denied.

Q Okay. And, Doctor, the first thing I would like for you to address is, can HIV -- and if you would in your answer just technically describe what HIV would be. Can the HIV virus be transmitted by introducing the blood of one person, who is HIV positive, into a wound of another person?

A There is no question in my mind that it can.

Q Okay. And would you describe with some technical precision, the percentages that are involved in that sort of environment?

A That is a good question. Nobody knows the exact percentage, because you could never do a study. You would never have somebody with open wounds and then splash blood into that wound and try to determine how often a person would become infected that way.

We do have needle stick studies, but those studies are very iffy at best. And the reason for it is that we don't know how many times, when there is a needle stick exchange. Or when there is a needle stick, that there is actually an exchange of bodily fluids. As an example, one study pointed out a .03 percent incident with a needle stick. But when they looked at the needle sticks and they separated the sticks where there probably wasn't an exchange, versus those where there was a significant deep wound, like to the palm. They found out it was like 17 percent.

Now, we do know this. There have been eight reported cases amongst nurses world wide, that have been reported, I don't how many it would be all together. But eight have been reported where nurses became infected from a blood splash injury to the face.

Q Okay.

A There is a case -- stop me if you want.

Q No. I just want to ask you a little bit more specifically about those cases. When you say they have been reported, where has that been reported?

A This has kind of been world wide. The last case that I am aware of, that I read, was actually a nurse in Spain. And the interesting part about that story was that it was mentioned that she had no obvious lesions on her face. In other words, there was no acne, there were no other cuts or anything like that.

Q Okay. Do you recall where this report was made?

A No. But I could try to find it. But I definitely know it came out of Spain.

Q Okay. Is this something that you would read in a medical journal?

A Yes, I read it.

Q Do you recall where you read it?

A No, I don't remember what journal it was reported in.

Q Okay. That is fine.

A It maybe Lancet, but I am not 100 percent sure.

Q Okay. Now, in terms of needle stick wounds, in which it can be demonstrated that fluid was passed into the person who was wounded. That the HIV infected blood of one person was introduced into an open wound, such as that, what would be the percentage at that point, that a person could have HIV transmitted to them?

A Well, you never know for sure that there was an exchange of fluids. In other words, even with a deep wound, it is possible that there was no blood at the tip of the syringe. Do you know what I am saying?

Q Right.

A But what we do know, if you look at

instances where there is a definite exchange of bodily fluids with needles, and by this I mean blood transfusions. And there are three reported cases, now, related to -- there is a certain thing we do in nuclear medicine, which is called a white cell scan. What you do is you take somebody's white cells, you tag them with a nucleotide and then you reinject them to do this scan called an indium scan.

There are three reported cases now, where people who were infected who had scans, and the blood was taken out, tagged and accidently put in someone else, in all three of those cases, they become infected. That is three out of three in blood transfusions. So, in other words, if you get blood from somebody that is infected, you know you are getting infected blood that is going into your blood, it is 100 percent.

There was a study in the annals, that came out a little bit after 1990, where they looked at people who had gotten blood from patients who were donors who were HIV infected. It was like, 100 percent.

So, in a ture [sic] bodily exchange, it is 100 percent. But we don't know in splash injuries, was there actually contact of blood to blood. We don't know the exact percentage of how many times there was actually blood exchanged or bodily fluid exchanged.

We do know one thing though. The real percentage that is significant to me, as a doctor, is if you do get infected, you are going to die. Nobody has been cured. The cure rate is zero. So, even if a small percentage, a .OOOl percent, is very significant.

It is like asking any of us would we get on airplane, somebody gives us a free ticket to Hawaii, and we get on the plane and the pilot comes on and says I hope you enjoy your trip to Hawaii and the weather is wonderful. I just have to tell you, there is one chance in 500 there is a bomb on this plane. Is anybody going to stay on the plane? We can talk about

how safe planes are, but if you know there is no survival if this plane blows up. You are not going to get on the plane, even if there is a small chance.

Q Okay.

A So, that percentage, to me, is as significant as any other percentage. And you don't take a chance with a disease that is so deadly. We are not talking about influenza. We are not talking about Hepatitis. We are not talking about Gonorrhea, Syphilis or any other typical communicable disease.

Q Right.

A This one carries a very close to 100 percent mortality.

Q Doctor, in that regard, if HIV is transmitted to a person, can you describe what the life course, I guess you would say, of the disease would be in the typical person who is infected with HIV?

A The average person, if you got infected right now, time zero, within about two to three weeks you may develop a very, sometimes it can be a little severe, feverish illness, with some aches, occasionally a fleeting rash. Then, it goes away and most of the time, you had no clue that was the initial AIDS infection. Following this, nothing usually happens for about eight to ten years. Your blood tests will convert about 95 percent of the time within three months, and 99 percent of the time within six months. All most 100 percent blood conversion by six months, but you don't become ill. People who are HIV infected, and fortunately for them, they don't get ill right away. You do have good quality life in front of you. But in an average of maybe eight to ten years, and this again is an average, it seems to be less than that if you are very old when you get infected. If you are infected early on in utero, as a fetus, it is probably earlier were you get sick, because your immune system hasn't had time to develop.

But on the average, about eight to ten years of having no symptoms, whatsoever. Following this, you start to develop the symptoms of fevers, unexplained night sweats, sometimes a cough and opportunistic infection set in, you may develop thrush of the palpus. This is a white tongue and it may go down into the esophagus and you will have difficulty in swallowing.

So, you will start developing the opportunistic infection, the classic ones being Pneumocystis, Cryptococcal Meningitis, and sometimes Mycobacterium Avium. I saw a patient two days ago, for the first time and he probably became infected nine years ago, seeing a prostitute in Mexico. He had absolutely no symptoms until three weeks ago when he starting having fevers. He happens to have a disseminated fungal infection, called Histoplasmosis. He also has multiple lesions in his brain.

Now, this probably started six months ago or a year ago, but he did not become symptomatic until three weeks ago. So, he had all of these years of feeling fine. He was communicable the entire time. I heard some tragic story this morning. We tested his wife, because the concern was that they have been married for a couple of years. And the concern was: What about his wife? He must have been sick for eight to ten years and he certainly could have communicated it to her. She tested HIV negative, a year before they were married. I got the report back this morning that she was positive. She has absolutely no symptoms.

Q Okay.

A This is an incredible tragedy that this disease was passed on from this man to the person that he loved most in his world, which is his wife. They have one two year old. The two year old will some day be an orphan. And we can only hope that this two year old is not already infected. And we don't have the status back on this child.

Q Doctor --

A This is what we need to prevent. So, the natural course is that you have many years of being communicable to others and yet you may have absolutely no symptoms.

Q Okay. After this eight to ten year period when you start to become symptomatic, how long does it usually take from that point until death?

A That depends very much on the host, meaning the person who is infected. How close they are going to be followed. What type of opportunistic infection set in first. We have drugs today that will prevent people from getting opportunistic infections or put it off a ways, prophylactics. Drugs like Septra to prevent pneumocystis, antifungal drugs to prevent fungal infections.

I do believe that we have extended peoples lives by very carefully monitoring for opportunistic infections. And when we detect them, we treat them earlier for those infections. We sometimes wind up treating people before they develop those infections, when their CD4 count drops to ranges that we know this is the range were you are going to start getting these infections. So, we are going to treat you now, to prevent you from getting them. And this is what we classically do.

So, the time period can be very variable. The young man that I told you about just a few moments ago, he was never followed by anybody. So, he presented with two horrific opportunistic infections and a CD4 count that is very low. His life expectancy from now to when he dies, is probably going to be measured in weeks, maybe a month. Other patients that I have, clearly I believe I can extend their lives by monitoring them closer.

Then, we also have the antiretroviral drugs, and these are the cocktail drugs, RT and protease. Most of my patients are on these drugs. But the response to these drugs is

very variable. It is very limited. And unfortunately for all of us, maybe the benefits are going to be much more short lived than we hoped for, because there is a lot of rapid development of resistance to these drugs. The virus develops a rapid resistance to these drugs. Not only do they develop resistance to the drugs that you are on, but there is a cross resistance. So, people who become resistant, as an example, to Crixivan may already be resistant to Ritonavir before they have ever even gotten the Ritonavir.

Q First of all, is there a different DNA or RNA, and please correct, so I am using the correct term, with respect to each individual's particular HIV?

A Right. This virus does multiple very quickly in your body. You make ten billion new viruses every day. It is continually mutating or changing, so you will get some different RNA patterns.

Q Okay.

A There are people who have significantly different RNA from other patients. And then there are some patients who have RNA that is very similar. That is one of the ways we can sort of track down if somebody got infected from someone else. If you suspect that person A got infected by person B, you can look at the RNA patterns. It is not an easy, readily available lab test, but it can be done. And we can match up the viruses RNA to see, in fact, if it may have been spread from one person to another.

Q Okay. If a person has AIDS and is on one of these cocktails, and that person transfers his or her virus to another person, is it possible that the resistance that may have been built up by that person's AIDS virus -- In other words, when he transfers that AIDS virus to person B, does person B's virus already a have certain resistance to some of these new drugs?

A That is a billion dollar question. It makes

since that you are going to have the virus that was in that other person's body. And that other person, being on therapy, will likely select out resistent drugs. So, somebody who gets infected today, is probably not getting infected with what we call an naive virus, meaning a virus that has never been exposed to drugs.

So, you are more likely, in my opinion, and again, this is just an opinion on this because the studies really haven't been worked out. But it makes sense that anybody infected today with the HI virus, is more likely to have a resistant strain than somebody who was infected three years ago, before we were using the protease inhibitors. So, yes, you do select viral resistance. And then, if you pass on your virus to someone else, it is more likely to be a resistant virus.

That is one of the tragedies we are dealing with now, is that it is very likely that unless we develop some incredible, miraculous drugs, we are more likely to see more viral resistance in the future than we even have already. And the therapy in the future, may, in fact, be worse instead of better.

Q Okay. Doctor, are you aware of any reported case in which a person has been infected by another person through blood spilled in a sporting activity?

A There is one reported case that I am aware of with HIV. This came out of Varese, Italy, this was in a soccer game. And one of the teams apparently had a number drug addicts on the team. And there was a head butt and after the head butt, they tested the HIV status of these players. And they found that one player was infected and one was not. Then, they followed the one that was not infected. And in, I think, two or three months, he converted his test and become infected. So, from that head butt and subsequent splash injury, this person became infected.

There is another recent report, it was an auto accident, actually, where there was a fight, if you want to call

fighting a sport, but there was a scuffle afterwards. And following this scuffle, one guy hit the other guy in the face and the guy was wearing glasses and the glasses cut into his face. The guy who hit him was infected and cut his knuckle. And the blood from the guy's knuckle, went into the other guy's face, who was wearing the glasses. And that person then, subsequently became HIV infected. I just heard about this case within the last, I think, month or two.

There is another situation, where someone got infected from a known bite injury from a prostitute. There are a number of reported cases of siblings, where one sibling became infected from the other. One of these was felt to implicated from sharing a toothbrush.

Q Okay.

A But, again, you don't get sick for six, eight or ten years, as we mentioned. So, if somebody become infected from a blood splash injury and didn't get sick for eight to ten years, they are not going to remember that eight years ago, I got splashed by somebody's blood on the school ground or something.

Q Right.

A Because you don't get sick within three to six weeks, as you do with other diseases, we often don't make that association. So, we don't know what the true incidence is. Before I forget this, this is important. The best model we have got for HIV is Hepatitis B and Hepatitis C. They there not exact, but they are the closest we can go by.

Q And why is that?

A Because the modes of spread are almost identical. If you look at the modes of spread of Hepatitis B, it is neonatally, just like with HIV. It is through shared needles. It is through blood transfusions. And it is sexually spread. It is the closest model that we have got. In Hepatitis B, there have been many reported cases and outbreaks in things such as dentistry.

But more than that, there are reports of a sumo wrestler who got infected from a blood splash injury. And there is a sport, it is an unusual sport, it is only practiced, to my knowledge, in Scandinavian countries, it is called orienteering. It is groups of men that go through the forest. It is a sport where you go through a forest to an end to see who the first person is to get to the end. And they are always scratched going through the brush. And there have been reported outbreaks of Hepatitis B in men on the same team, who splashed themselves with each others blood. So, that is the other sports related cases that I am aware of with Hepatitis B.

Q Okay. Now, in Dr. Suzanne LaVoie's deposition, it was indicated, and she acknowledged, that in certain family settings in which there was a shared toothbrush, there were reported cases of HIV transmission. And she indicated that that was a situation in which there were multiple opportunities for the infection to be passed.

Now, would you be able to determine, if that were the case? In other orders, if it was a shared toothbrush between family members, would you be able to determine by the way that the medical community tests for HIV, whether or not such an infection occurred on first or on the last exchange of that toothbrush?

A You have to just keep doing HIV testing and then just see when the conversion occurred. You can test for antigen now, so, you can actually pick it up sooner.

Q Okay. But my question though is if you find out --

A If they shared a toothbrush over five years, every single day, you wouldn't know when the conversion was unless you checked them. But it only takes one hit, it may only take one virion we don't know. Obviously, if you shared a toothbrush every day, your risk is probably greater than if you did it one time. Just like with sexual exposure, you have greater

risk the more you do it. But you don't take a chance even once, I mean, once is too much. Because it only takes the one time and that is it, there is no reversing this disease.

Q Now, Doctor, first of all, what I would like for you to do is to describe, if you would -- I am going to try to phrase this properly, because I don't want an objection to my question. Would it be fair to say that the knowledge of HIV and AIDS in the medical community is something that has been in a stage of transition from the first onset or the first reported cases of AIDS?

A I think that we do learn more as we go along. But I think more than knowledge, I think, that we have been intimidated about speaking up as physicians. We don't want to sound wrong. We don't want to be politically incorrect. We have been willing to be quite and silent, when we should have been speaking up from the beginning.

We have known about how Hepatitis B is transmitted, long before we have had the AIDS epidemic. Then, when we started realizing hemophiliacs are getting HIV, getting it from blood transfusions, getting it from sexual spread. The same risk factors seemed to apply for both. We should have been speaking up from the beginning, and not waiting for cases to happen.

I can give you an example of where we knew something, but we waited. And this is --

Q What would that example be?

A The CDC has done a study with discordant couples, basically this means one couple is infected and the other one is not. They were not engaging in sex. They were only engaging in kissing activities. And they were following these couples over a number of years. In 1995, in one of couples they were following, the reason they were following them is because they knew it was a risk factor, they identified that the other couple became HIV infected. And it was through

wet kissing. In other words, passionate kissing exchanging of bodily secretions, saliva or whatever else was in the mouth, sometimes blood. And they knew about this in 1995, and they had been studying this couple. It took them until July 1997 to report this case.

Why did they wait two years to report it? They knew about the mode of transmission even before this case was identified, from everything else we know about Hepatitis B. And that is why they studied this couple. So, these things have been known for a long time, and we don't speak out. It is politically wrong.

Q All right. Doctor --

A Another example is getting infected from sperm donors. In the State of New York, they identified women who become infected from donated sperm. It took them four years to have required testing of sperm donors. Yet, they knew this was spread this way, but they didn't want to do anything about it. So, I think a lot of the things that we think we are learning now, we really knew all along, but we just didn't do anything about it. That is way I see it. I think that we have been so silent on this is disease, that if we say something that somebody else doesn't want to hear, we don't say it because it might not adjust or be satisfactory in their wishes or their desires. So, we have kind of ignored the science of this disease to fit our behavior.

Q All right. Doctor, would it be fair to say that the methods of transmission of AIDS were initially thought to be much narrower than we are finding today?

A I think they were publicized as being narrower, but, again, it is the same thing. I, personally, have been very suspicious and am never surprised when I hear about people who get this, like we have seen with Hepatitis B. So, I would say, yes and no to your answer. Yes, in that we have not discussed a lot of the other modes for transmission. And those

other modes, again, are much more minor. I mean, for every splash injury, there are many more cases of people who have gotten it from sharing needles or sexual exposure. But those other risk factors are still there.

So, I would say that we are now talking a little bit more about those other risk factors. But I think many of us have recognized for a long time that those other modes of spread were always possibly. It is just that it takes time. We are really at the beginning. We are only in the first 16, 17 and 18 years of this epidemic, so there are a lot of things we don't know.

When you think about people not getting sick for eight to ten years, it becomes very difficult to identify risk factors. As an example, this person in Varese, Italy, the soccer players. The only way we know that that other soccer player become HIV infected, was that he was followed along. Had he not known there was any risk factor from that head collision, he probably would never have been checked. He night have gotten sick eight years from now, or from the time he was injured. And he might have infected thirty people along the way.

Q Doctor, in the blood splash cases that you are aware of, and in the case in Varese, Italy that you have described, were there any other known factors that would have led to the transmission of HIV? In other words, IV needle use?

A The report stated, no. But I was not a doctor in that case to know all of the ins and outs. But the report stated that this was the only risk factor that was involved in that case.

Q Are you aware of a case involving Dr. David Acer?

A Yes.

Q And would you describe, very briefly, that case. Dr. Acer was a dentist in Florida; is that correct?

A Yes. I think it was in Jupiter or St. Lucie,

Florida.

Q Okay. And could you describe that case for us, please.

A I will tell you as best I know it. Let me preface this by saying it is often called a fluke case. But the fluke thing about this case was that Kimberly Bergalis, who is the person who was first identified as being associated with Acer getting infected, the fluke of it was that she got infected very early. This was a young girl, I guess, she was in her late teens. She was clinically sick with AIDS. She thought she had no risk factor, and she reads in the newspaper about David Acer, who is infected with AIDS. And she said, my god, that is my dentist. Again, I am giving you the way I was told. So, I maybe don't have all the facts.

But apparently it was a newspaper article or the radio, I don't know. But anyway, she reads about him being infected and she said, this is the only way I could have gotten infected. So, with David Acer's permission and the permission of his lawyers, public health was able to test other patients of David Acer. And they looked at his blood and they looked at Kimberly's blood, and something you had brought up, the RNA patterns of Acer and Bergalis were almost identical, suggesting that they very likely connected in some way.

Q And were there any other reported risk factors, such as sexual activity or IV drug use?

A That is always controversial. No IV drugs. There was one rumor that she might have had some venereal warts. So, the question was: Did she have sex with someone else? She emphatically denied it to her death. Nonetheless, what they did, which was interesting, is they went ahead and tested his blood and her blood, and, again, with his permission, public health was able to go ahead and notify other people who had been treated by David Acer.

They identified five additional people in his

practice, who were not only HIV,infected, but had the same RNA as Acer and Bergalis. None of those other people, apparently, had any significant risk factor. But, again, you never know 100 percent, but it was very suggestive. It was also interesting that when they went ahead and did the screening, I think, it was 900 to 1,000 people, they found five additional people, besides those five, who were also HIV infected also without significant known risk factors, who didn't know they were infected. But they had different RNA patterns.

So, by just doing appropriate public health hand screening people, they were able to identify ten people who were infected. This should have told us, if anything else, we need to do screenings for this disease. Because those ten people now, knowing that they are infected, hopefully will behave in such a way and live honorably in their life and not infect other people.

But going back to your original question. In that particular case, it certainly appears that it came from the dentist in some way or another, and that it was not just Kimberly Bergalis. But the fluke in this case was Bergalis didn't get sick in eight to ten years. I told you that that is the typical time period.

Q Right.

A But that doesn't mean that a small percentage of people on a bell curve might get sick in one or two years. And some people may not get sick for twenty or twenty-five years. We don't know that, yet. But it maybe that long. So, she got sick early, and as a consequence of being sick early, they were able to track it back to David Acer.

Q Okay. There were no reports of her having sex with David Acer? Or sharing a needle with him; is that correct?

A No.

Q Okay.

A What I think we have learned also, is we have looked not just at the Kimberly Bergalis case. At the beginning of this epidemic, it seemed that everybody had a risk factor, if you checked hard enough. In 1982, 1983, 1984 when you got sick, you were engaging in activity that would have put you at risk.

It is very interesting, South Carolina reported this past year, that ten percent of their cases had no identifiable risk factor. Where, at one time, it was much less than one percent, it was up to ten percent in South Carolina. That means that ten percent of people, after you questioned them, you did all the kinds of questions we did years ago, asking those same questions, ten percent didn't seem to have a risk factor.

In our county here, we found the same number of ten percent. That is very high, that is unusual. But we are seeing this pattern now, where more and more people are infected, who did not have the typical risk factors that we thought. And that is a very frightening change in this epidemic.

Q Doctor, would you describe what universal precautions are?

A Universal precautions are what we do when we don't want to practice public health. And universal precautions should be part of prevention. But it basically means, assume everybody is infected. That means when I see a patient, regardless of what the reasons are, I should be wearing gloves. It means that I should take the precautions as if everyone that I might see or you might see is infected.

So, we do this in the hospital. It means that I wear gloves in the hospital. When I see patients, the way we deal with sharps, you know, special procedures that are used in order to dispose of equipment. It is interesting, John Hopkins had two doctors who became infected with AIDS. And they did probably the most stringent universal precautions you could do. They tried to do everything right. And they found that with the

best of universal precautions, they couldn't do better than 20 percent in the hospital in risk reduction. 80 percent of the injuries couldn't have even been avoided with universal precautions.

Now, I am not saying that we don't practice careful universal precautions. But the most important precaution you can take is to know the status of your patients. You do change the way you practice surgery, when you know. And this is the way life works. So, that is biggest of all precautions we refuse to take, and that is to know who is infected. It is not to punish anyone, it is to protect people.

Q All right. Doctor, in terms of surgeons, they routinely wear masks and gloves in surgery --

A Absolutely.

Q -- even when they do not have an open wound; is that correct?

A Absolutely. They take precautions, but they are not even good enough. In other words, even with those precautions, you can still get infected 80 percent of the time. You can reduce it by about 20 percent and you operate slower as a consequence. Surgeons are very frightened about getting infected.

Q Okay. When you say get infected 80 percent of the time, are you saying that you get infected 80 percent of the time that you would have otherwise gotten infected?

A Yes. I shouldn't have used the word infected. The exposure.

Q Okay.

A You can only reduce the exposes, at least in one study, where they did very stringent observations and universal precaution they found that it was a 20 percent reduction. 80 percent of the injuries could not be avoided even

with the universal precautions.

Q Do you recall where that study was from?

A John Hopkins.

Q Getting back to surgeons, when they operate, they wear covering on their eyes; is that correct?

A It varies from hospital to hospital. But sometimes they double gown, they double glove. The way, again, the instruments are handled. They wear a mask over their face. It is harder to operate, today.

Q But my question, specifically, is: Does a surgeon take precautions to make sure that the area of his eyes would be covered if he is in an environment where blood might be splattered?

A Yes.

Q All right. Why?

A Because you can transmit HIV and other viruses that way.

Q Through contact with the eyes, without an open wound?

A You know, we could say that it happen with other viruses. With open wounds, it can happen. But even a blood splash injury on the skin, on intent skin, theoretically can also spread viruses. And the reason I say that is this: 1. Nobody's skin is really intact. We all have pores in our skin. There are Langerhans cells on the skin that actually have CD4 receptors.

Q What is a CD4 receptor?

A These are receptors on cells that combine the virus.

Q And that would include HIV?

A Right. So, even if the skin is intact, theoretically, it can get through intact skin from CD4 receptors and Langerhans cells. But we all have pores in our

skin, so, our skin is not 100 percent intact. We all shave. We all have acne. You can fit one virion, 100,000 viruses into a hole that you can't even see. The virus is tiny, it is only like 90 manometers in size. So, nobody really has totally intact skin.

The last case, the Spanish nurse. One of the reasons that case was brought to the attention of people is that the claim was made that she had absolutely clear skin and the splash injury occurred on intact skin on the face. So, to me, I would never ever want anybody to be splashed with blood, even with intact skin. I do not consider that safe. I would never want anybody to be exposed to HIV infected blood.

Q All right.

A It is just not worth taking the chance.

Q All right. Doctor, in terms of saliva, saliva has some qualities or enzymes, does it not, that would normally inhibit the transmission of HIV?

A Well, there are enzymes in saliva that are called skippies [sic], I think is the term that is used for it. Basically, they are enzymes that can inactivate viruses. But if you have got fresh virus coming into your mouth, and we know that there is HI virus in saliva. It is much less than in blood, but it is in saliva. There is no guarantee that the enzymes in your mouth are going to immediately inactive every single virus that might be in your mouth.

Q And in that regard --

A But if you have blood in your mouth, you have now got a lot of virus, not a little.

Q Would it be possible through agitation -- for instance if one were to be punched in the facial area, would it be possible that that type of agitation could introduce blood into the saliva?

A Any time there is any kind of a cut in the mouth, absolutely. But more than that a study was done, this was also in Italy, of people just brushing their teeth. And this

study showed 91 percent of the time just brushing your teeth, you introduce blood into your mouth. When you eat, it is probably over 50 percent. And from just passionate kissing you introduce blood into your mouth. You have got to remember the average infected person has between 102,000,000 virions in their body at any one time. You blood is teeming with virus. And it only takes one virus, as far as we know, to initiate infection. So, no question about it in my mind, that even a minuscule amount of blood in the mouth is a risk factor. And probably even no blood in the mouth is a risk factor. There is not one doctor that I know that would dare have their child swapping saliva with someone that is HIV infected, even if there is no blood in the mouth. You don't do that. It is too dangerous.

Q Okay. So, --

A You can do that with flu and other diseases, but it is unethical to ever exchange any bodily fluid with any one that is HIV infected.

Q All right.

A Blood or no blood.

Q In your medical opinion, would it be probable for someone who had either had blood introduced into their mouth through some agitation or perhaps even not, if that saliva came in to contact with an open wound on another person, and the person whose saliva came in contact with that open wound was HIV positive, in your medical opinion, would it be possible that HIV could be transmitted in this manner?

A Yes. I would never expose my child to that possibility or my wife or anyone else. If my child was infected, I would never ever want anybody else 's child to go through the trauma that my child would face in dealing with this disease down the line.

I do consider it a risk. It may not be as great a risk as sexual exposure. It may not be as great a risk as sharing needles. But the risk is still there, and you didn't take that kind

of chance with this disease. You don't jeopardize other people's lives.

Q Would it be a possibility --

A At least I don't.

Q I understand. In your medical opinion, would it be possible if the person with the open wound, in other words, let many give you a hypothetical. A child who is HIV positive strikes another child who is not HIV positive in the facial area, specifically in the mouth, and a wound is opened on the hand of the child who is HIV positive and as a consequence, some of that blood spills into the mouth or the eye area of the other child who is not HIV positive. In your medical opinion, would it be possible that HIV could be transmitted in that environment?

A Absolutely. And I would be so, so upset knowing that something like that happened when it could have been avoided. Absolutely.

Q Would there be any way, through what you know of universal precautions, to prevent that in a combative situation, such as I described?

A I guess, if they were fighting or engaging in total body armor. If you could totally avoid, you know, an exchange of any bodily fluid, then yes. But how do you do that? You would have to be fighting in steel armor.

Q Okay.

A The risk is unquestionably there. It is not a matter of are we taking about one percent or a half percent. What we are taking about is if you get infected, the cure is zero. It is better to have a 90 percent chance of spreading a disease that has 100 percent cure than having a lOOth of one percent chance of spreading a disease that has no cure. So, you know that is why a small percentage is a very significant percentage, when we are talking about AIDS.

Q All right. Now, the next question I have

for you is --

A Public Health shouldn't even allow this situation to happen. Public Health, as soon as they are aware that there is this kind of potential for spreading the disease, this health department should be all other a situation like this. And asking what are we thinking of? This shouldn't be and issue for you lawyers to be discussing. Public Health should be dealing with this and should never allow this circumstance to happen. And sooner or later, the public is going to become outraged and I don't know how long that is going to take. How many people have to suffer?

This poor child Michael, I wish him the best. He deserves the best of care. But I hope his parents, his friends and he, himself, understand that nobody else should have to go through the pain that he is going to some day face. We need to help Michael. But his biggest problem is not going to be if he is taking karate classes or not. His biggest problem is that someday he is going to face guys like me who are going to have to offer him drugs, and the drugs are not going to be as good as he hoped for.

And he is going to go through a lot. And we need to empower young people like Michael to not want to spread this disease, whatever the odds are. If they are . 001 or 1 or 2, those are too high.

Q All right. Doctor --

A Sorry to interject.

Q That is fine.

A It just upsets me as a parent and as a doctor, that we are squabbling over these numbers, when we are talking about a deadly disease. The judge or the lawyer or whoever, would never want your children exposed unnecessarily to a deadly disease. And there is a risk factor, who are we kidding to say there is not?

This is what is so absurd to so many of us who

hear this. And we wonder why is this in the courts? If somebody should get infected at this karate school, or whereever, the health department should be held responsible, not Michael. It is not his fault, he didn't know better as a child. Give this kid a break, it is the health department th_at needs to be involved here.

Q All right. Doctor, in terms --

A I will challenge any doctor in the world on that. I don't care.

Q In terms of the drugs that are being administered, is it true that with some of the new cocktails and some of the new inhibiting drugs that the level -- you described earlier the amount of virions that would be present in a person who is HIV positive. Do we know whether or not the level of virions is actually reduced when a person is taking these drugs?

A Yes. We do know that we can decrease the amount of virus in peripheral blood, this is called the viral load. In some patients, it cn actually be non-detectable in peripheral blood. But the reason it is non-detectable is that our assay is only so sensitive. Now that we have better tests, we have found that a lot of people who were undetectable at below 400, in fact, had levels between 25 and 400 copies.

So, we do know that we can decrease the amount of virus in peripheral blood. It is often temporary. For some patients, that temporary may extend into twelve months or longer and in some patients it maybe just a few weeks. But we can decrease the viral load in many people. But remember we are talking about peripheral blood, 98 percent of the action of AIDS not in peripheral blood. It is in your lymph nodes. 1. In every single patient, where we can drop to levels that we have a difficult time detecting the virus, in every one of them, once the drugs are stopped, within three to four weeks, the viral is right back to where it was. 2. We know that can measure proviral,DNA in the lymph nodes of patients. So, the virus is

still there.

Does this make you a little bit less communicable? Possibly. But is that good enough? If the pilot now came on and said, well, I was wrong, there is not a one percent chance of a bomb on this plane, there is only a half of a percent chance there is a bomb on this plane. Would you still board the plane?

It is the same scenario. Yes, theoretically, we can make people a little less communicable. We don't know that for sure. It would seem that if you have less virus in the peripheral blood, you have probably got less virus in your body. But again, it only takes one virion.

Q Did you not say that it could be a very short period of time in which that viral load might change? I think, you said, twelve months to three to four weeks?

A There a patients now, since the protease drugs have been out, sixteen to eighteen months now, who have been on it, there are a few people who have been on it this whole time. The majority of people on it have failed, are no longer on it or had to take other drugs. But there are some patients who have been on it for a long time and who have very suppressed viral loads for a long period of time.

That leaves some optimism and hope for people that are infected that maybe this will equate to suppressing the virus in their body and how long can they tolerate these drugs. Hopefully, for a long period of time for those that are unfortunate to be infected. But I don't believe that this makes you noncommunicable.

No doctor in the world would ever want to be transfused or splashed with blood by somebody who is on the cocktails., even if there is non-detectable virus in their blood. That ain't good enough.

Q All right. Well, doctor, if the person was seen by a physician and it was determined that the viral loads

had been reduced, and then a period of time went by subsequent to that examination, would it be possible that during that period of time the viral loads would increase even if that person was still taking medication?

A I have had patients who had gotten their viral load down and everything seemed fine for a few months. And then, I repeated their viral load and all of a sudden it was back up. They felt the same, they felt fine. But their viral load was higher, it had climbed during the period of time of the two tests. So, that happens all the time.

So, in other words, you can test somebody and they can drop their viral load on treatment, and they can be less than 400 for three to five months. And then, you get another test done, and all of a sudden, they are back to 30,000. And they felt fine during that interval, but the virus broke through or the patient stopped taking their meds.

The compliance on medication is very poor. A very many patients stop their therapy and don't even tell their doctor. So, we don't know how many cases where there is a break through and the viral load goes up, how many cases was poor compliance on the part of the patient versus viral resistance or a combination of the two.

Q All right. And specifically, my question would be: If an individual's viral load was measured and found to be low, and later was in a situation in which blood was exchanged with another person, would it be possible that that viral load in a short period of time could increase and thereby increase the chances of transmission being made?

A After the exposure to someone else, the viral load goes up?

Q No. In other words, I am HIV positive, as a hypothetical, my viral load is very low. Three weeks later, I an engaged in combat with some one and there is a blood splash or an open wound in which my blood is introduced into

someone else's. During that three week period of time, is it possible that the viral load can increase, even though I am on medication?

A Absolutely.

Q And thereby make it more dangerous in terms of the percentage of transmission?

A Absolutely.

Q Okay.

A Yes. We don't know what time, unless we did a viral load every five minutes on you, we wouldn't know when it started to climb again. So, sure. But even when it is low or non-detectable by our assay, you still have the virus in your body. It is still unsafe. It just might be a little bit safer. If I had my choice of being splashed by somebody with a viral load of 500,000 or a viral load of 1,000, of course, I would take the 1,000. But I would be very, very uncomfortable with anybody that is infected regardless of their viral loads.

An example, women who are pregnant certainly can spread the virus to their newborn. The incident maybe less,. it appears to be less in women who have less virus. But it has also been shown that women with undetectable virus have also spread the virus in utero. So, it can happen. It may diminish the odds a little bit or a lot. But a lot ain't enough, if there is any chance that you could get infected.

Q Doctor, a lot of the information that is present today, in terms of percentages of transmission and such, they are based, are they not, on either animal models or computer models?

A Well, studies were done with the needle stick exposure. And there it was found, you know, to be a low incidence. But when you looked more carefully at the studies, you found that in well over 80 to 90 percent of the needle stick exposures there was really no exchange of bodily fluid.

Q Okay.

A Now, there are animal models of exchange. It is interesting that you bring that up. Let me just share one with you, if you don't mind. This was a study that come out in Nature in 1995. It was an animal study with the simian AIDS virus. Monkeys have a virus called SIV, simian immunodeficiency virus. They get a disease called AIDS. And what was done in this study, they took the intact mouths, there was no injuries to these monkeys. They took rhesus monkeys and they dabbed the backs of the tongues with simian AIDS virus. And they found that six out of seven monkeys in this animal model become infected with simian AIDS and got SAIDS.

Now, it is interesting the inoculum size that it took to infect these moneys through the mouth was 1/6,00Oth of the inoculum size it took to infect these monkeys rectally. So, here was an example of the closest model we have got. It is not exactly the same, but you got to go by the best science we have. And we looked at the monkey model. And in the monkey model, we found it was very easy to infect these monkeys through the mouth, six out of seven monkeys became infected that way. Nobody knew what to do with the study, so we kind of like put it on the side. But it is obviously a worry in everyone's mind that if this can happen in the monkey population, it can certainly happen with us.

Q Is it possible that that study came from a periodical called Science?

A It was either in Science or Nature. I remember the author was Baba, B-A-B-A, I think, and it was out of New York. If you want to. II wait a second, I can look it up.

Q First of all, is there anything about the human body that makes the human body more accessible to the AIDS virus than to any other animal?

A We are susceptible to human AIDS, just

like monkeys are susceptible to Simian AIDS. And there is cat form of AIDS called Feline AIDS or FAIDS, caused by FID. But it seems to be a species specific virus. However, we don't know how humans got AIDS, and it is very possible that it jumped species. And this thing happens, now and then, where a certain -- in other words, this could have been in the monkey population, as Simian AIDS, and just jumped species. In other words, it mutated enough that it then become a human AIDS virus. Now, the human AIDS virus doesn't go back to the money, unless it mutates.

Look at what we are seeing with influenza in Hong Kong right now. Where it went from the swine population into the avian population, and now infecting human. So, these things occasionally do happen. But they are very similar viruses, SIV and HIV. But monkeys don't get HIV, like humans don't get SIV. But HIV could have started from SIV.

Q Doctor, I am getting close to end of my questions for you. In the early stages, when the early --

A The article was in Science.

Q It was Science magazine?

A Science. It was -- I will give you the exact reference here. It was Science and it was written by a guy named Babatw. And it is Infection and Aids in adult Macaque after Non-traumatic Oral Exposure to SIV. It was in Science, June 7, 1996.

Q And this was the study in which --

A It was Macaque. I was wrong on the monkey strain, it was Macaque monkey and not rhesus monkey.

Q Okay.

A And it was in Science, June 7, 1996, 272: page 1486 to 1489.

Q And this was when the --

A It was a big news event at the time.

Q -- the virus was simply put on the back

of the tongue, with the no open wounds?

A Yes. Just dabbing the back of the tongue.

Q Okay. Kind of finishing up and wrapping up. Doctor, would it be true that in the early history of AIDS, it was originally thought by certain of the medical community, that AIDS could only be transmitted within -- for instance, was it first considered just a homosexual disease?

A I think that is such a broad question. Obviously, there are people that still think that. It is a human disease, and it relates to . your behavior. And it relates to promiscuity. And it relates to how often you are going to expose yourself to bodily secretions of someone that is infected. Sadly, for the gay community, they have been devastated by this disease. And because so many young gay men are infected, it puts other gay men who are not infected at tremendous risk.

Q Didn't the first name that the medical community gave to what we now describe as AIDS, was it not described as SIDS initially?

A Yes. It was initially thought of, in kind of a laymen's term, as a gay disease. But it certainly, I mean, I can't speak for all doctors, but I never wanted to look at it as anything more than a human disease.

Q Okay.

A Well, even today, 56 percent of all the new cases are still young gay men. I mean, that is still tragic. Earlier on, it was closer to 80 to 90 percent. So, as a percentage, they have dropped. But they have dropped because other groups are catching up. Women now make up 25 percent of all new cases in this country.

Q How about children?

A In fact, adolescence are one of fastest growing groups. It is estimated that one adolescent becomes infected in this country, every 20 minutes.

Q All right.

A So, that is the group that is such a concern for all of us. But it doesn't matter who you are, it is a horrible nightmare for anyone who becomes infected.

Q All right. Is there anyway to put a percentage, in terms of if a person had blood, and I understand it is not a precise scientific measurement, but if what you might consider was a drop of blood was introduced into an open wound, and the drop of blood came from an HIV infected person in the combative situation, which we have discussed. Hypothetically, is there a way to put a percentage of what the risk of transmission would be?

A I don't know that I could give a percentage. I could tell you that anything above zero is too high. Yes, in my opinion, that kind of 'injury, of dropping blood into an open wound, I consider that to be a very significant risk factor not a minor one.

Q All right. If the HI virus is transmitted to you,. and you don't either die from some injury or some other disease, what is the percentage that you are going to ultimately die from AIDS?

A Well, it is sad to say this, but the cure rate remains zero. And I think that it approaches 100 percent.

Q Thank you, doctor --

A If I look at my patients back in early part of this, even now, it is 100 percent.

Q Okay. How many AIDS patients would you say you see on a weekly basis?

A At any one time, I follow between about 20 to 25. I get tons of call and I assist other doctors with their patients. I am not always the primary care giver. I will often be giving advice or consultation to others. I have followed this epidemic, literately from the first days. I trained at San Francisco General. And I took care of two people back in 1980,

before we knew about AIDS, who clearly had pneumocystis and died of opportunistic infection. It was only a couple of years later, before we saw that we were in an epidemic here.

Q All right. Doctor, do you have children?

A Three.

Q What are their ages?

A 17, 15 and 13.

Q Would you allow your child or anyone one of your children to participate in a karate class, in which you knew that your child would be engaged in some form of hand to hand combat with an HIV positive individual?

MR. RANEY: Objection.

A Under no circumstances.

MR. RANEY: Excuse me, doctor.

MR. COLLIER: Hold on a second, doctor.

MR. RANEY: Let me state my objection.

A But I want to go further.

MR. COLLIER: Wait, doctor, you have to let him state his objection for the record.

MR. RANEY: The personal opinion of the witness is irrelevant in this matter.

MR. COLLIER: And my response to the objection would be that --

MR. SAVITCH: Medical opinion.

MR. COLLIER: He is an expert. He is qualified to give his medical opinion, based upon his expertise. And it is relevant. Doctor, you can answer the question, now.

A There are two sides to this coin. One side is that I would never ever have any of my children, or any child I know in the world, exposed unnecessarily like this. That is number one. But the other side of this unhappy coin is that heaven forbid my child should be infected, I would never ever allow my child to expose someone else. I want my children to go up with honor. If they are unlucky enough to be infected, so be it. I don't care who knows about. I don't want my child to ever expose any other child in the world. So, either way it would never happen in my family.

MR. COLLIER: All right. Doctor, I don't have any other questions. Mr. RANEY is going to question you now.

MR. RANEY: Dr. Savitch, I am Terry Raney. I am Mr. Montalvo and his son's attorney. Thank you for your patience with us.

CROSS-EXAMINATION
BY MR. RANEY:

Q At the outset of your deposition, you mentioned eight reported cases of individuals contracting HIV through blood splash incidents?

A These were nurses.

Q Say it again?

A All the cases were nurses.

Q Okay. Nurses contracting HIV through blood splash exposure?

A Right.

Q And you talked about the nurse in Spain.

A Right.

Q Do you have a reference that one of us could go to for the information concerning any of those eight cases?

A Yes. I would have to look it up, 'I don't have them in front of me. But definitely, yes. In fact, one way you may be able to get it is through maybe the internet, online.

These cases have been discussed in various articles, so I know that they are available. I don't have them right in front of me. I can try to find them or try to get them on the internet. But that is not something that has not -- in other words, this has been discussed. I think in the last case, I believe that report discussed some of the other cases.

Q In regard to people participating in sports activity, do you have any information concerning sports participants who through that activity, other than the soccer head butt incident, where individuals have contracted AIDS or HIV through sports participation?

A That is a very good question. Because it is the key of everything that we are doing, is that we don't do the testing. So, there would be no way of knowing. And if you become infected eight years later you would never have made the original association to how you may have been infected. So, the answer is because we don't do universal screenings, and because this disease does not create symptoms for many, many years you would not make that association. So, there would be no way.

If this was Hepatitis B, pertussis or something else where you would have gotten infected engaging in sports, then the answer would be we would be able to do it. So, there is no way that you can do that. That is something that we should be doing. If we did universal screening, in this country, at appropriate public health, then we would have a chance of answering that question.

I hope the incidence would be low, because I don't know how often there are blood splash injuries. There can be a million blood splash injuries, but if each time the person is not infected, there won't be any spread of AIDS. The only way

you can get AIDS is from somebody who is already infected. So, you would have to know how many people were infected or who was infected in order to know if that can happen.

Q Is it your position, as a person involved in public health and a doctor in infectious disease, that for example, every athlete participating in college athletics should be screened, tested and identified in regard to HIV status?

A It is my believe that every athlete and every non-athlete, that means me and you, should know our HIV status. Because if we love our fellow human beings, we would want to know if we were infected so that we would be able to avoid any inadvertent injury to someone else. So, my answer to you is: Yes, for every athlete. And yes, for every non-athlete. And I know that may not sound politically right, but I consider that to be morally right and medically right.

Q You discussed a situation involving an automobile accident and an altercation between the people who were involved, and the possibility that AIDS, HIV was transmitted from an infected to a non-infected person. Do you have a reference for that incident, please?

A Yes. Actually, where I read that, because this was very recent, I read this in what is called the HIV Report. And it was put out by Congressman Tom Coburn, in Congress. And it is HIV Report, and I am 99 percent sure that is where I read this. And it was really within the last few months, I don't even recall what state this occur in, maybe florida, but I am not 100 percent sure. However, I will try to get you that reference. Or if you like, call Congressman Tom Coburn's office in Washington and ask them to send you that reference, because I am 99 percent sure that is where I got that from. But that did occur and this was very recent. It related to an altercation after an accident, where the glasses cut into the guy's nose or the bridge of his nose.

Q Another incident you mentioned was a

prostitute who bit a customer and apparently transmitted AIDS to the individual?

A Right. This was reported in the Miami Tribune, about a year, year and a half ago. But again, these are fluke cases, they are fluke, only that we are able to identify them. There could be thousands of cases for every one that we identify, because we don't do the testing. We don't do the monitoring. And if you don't get sick for eight to ten years, you are not going to know how you become infected. That is what makes this disease very different than other communicable diseases. There is a tremendously long, latent period without symptoms.

Q So, again, it is your position that each individual should know their HIV status and be required to find out what their HIV status is; is that correct?

A I think it should be in our hearts that we all know our status, so that we don't inadvertently harm someone with such a deadly disease.

Q Are you familiar or have any professional contact with Dr. Suzanne LaVoie, from the Medical College of Virginia?

A No. Except you guys mentioning her name earlier.

Q All right. Are you familiar with the epidemiology studies of Dr. Redfield and Dr. Bancroft and Dr. --

A Redfield is the guy from the military, I believe; right?

Q Walter Reed Army Institute of Research, that is correct.

A Yes. I read lots of studies and articles. You would have to give me a specific study. There is about 500,000 articles written on AIDS, so you would have to tell me which specific one.

Q Okay. From your position as infectious disease medical doctor, is it an acceptable professional practice for a doctor, nurse or other health care practitioner to refuse health care services to a person who has AIDS?

A I think you have to take the individual circumstances. I, as a doctor, never would refuse to care for anybody with AIDS. I do believe that there may be circumstances where it would be much wiser for somebody who is already HIV infected to take care of the patient with AIDS, if they are going to be doing a procedure that carries a high risk.

As an example, if you told me that your daughter, this is a hypothetical example, was a vascular surgeon. We know that the incident of needle stick exposure is very high there. And a person came in with terminal HIV disease. And that person was going to have open heart surgery or wanted open heart surgery, I would suggest that you try to find a surgeon that is HIV infected.

Every surgeon I know, in private, is very frightened to do high risk procedures on patients that are HIV infected. That is a fact of life that can't be denied. And this is something that is often not discussed publicly, but that is how they feel. And I can say the same thing in dentistry. That many dentists, if not all, are very frightened to do procedures on patients.

I don't do procedures on patients. I take care of patients. I do spinal taps and occasional joint taps. And there is a risk, and that risk I accept as part of the my profession. But I don't believe that we should be doing unnecessary procedures on patients. For the most part, the vast majority of doctors I work with are more than glad to provide care for patients that are HIV infected. And thank God for them. But there may be circumstances that can arise, where I would feel that a procedure should not be done, where there was a risk to the surgeon and very minimal or no benefit to the patient, and there

is a risk of spreading the disease.

I understand that, and I can't verify this, that six anesthesiologist have now die of AIDS in the Los Angeles area. This was just told to me the other day by an anesthesiologist. And they got infected ,through their job and not though other means. So, things like this do happen, it is real. Don't take unnecessary chances.

The perfect example, let's just say, hypothetically, this young boy should infect someone else, and this someone else didn't know it. Now, this person is sitting for six or eight years HIV infected and doesn't know it. That person is going to now potential expose a surgeon, a dentist or a lover or whoever. So, this is why you have to know your status.

I consider it unethical for doctors not to demand that we practice public health, so that people do know their status. And then, have the opportunity to act responsibly.

Q Even though there is risk to the health care person, it is still your opinion that the health care person provide the care to the patient?

A I think that you have to weigh the risks there. I can't say with 100 percent, every single time a health care provider should put themselves at risk if there is not going to be a significant benefit to the patient.

I don't think, as an example, that if a patient is terminal with AIDS, that a health care worker should do a procedure that has a chance or significant chance of getting infected themselves. If it is not going to save the life of someone that is infected, you are just doing an elective procedure.

So, I truly believe, and I will buck the medical trend on this, but I know privately every doctor agrees with what I am saying, but doesn't want to say it publicly. There are circumstances, where I believe a health care worker or health care professional should not do a procedure on a patient that is infected, if the benefit to the patient is only marginal and the risk

to the health care provider is significant.

Put your own family in that situation. Would you like your son or daughter to do a procedure where there was one chance in thirty, by doing open heart surgery where you cut yourself closing the sternum on a patient that is infected, knowing that the benefit to that patient is marginal at best, and the risk to the health care provider is significant?

That is not being a barter. If anything, you are spreading the disease that way. So, there are circumstances, I truly believe, where a health care provider should consider whether they should be doing a procedure on a patient. That is not the majority of times. Myself, as a doctor treating AIDS patients, I don't do those kinds of procedures. I am not a surgeon, so, I am not put in that circumstance. But it is a very difficult, ethical decision, when I have to ask a surgeon to do a procedure on a patient that is terminal, where I know I am not going to save that person's life. But just to make a diagnosis, I put that surgeon at risk.

And example would be, burrowing through the brain on someone that has a CD4 count of ten, who has got multiple opportunistic infections, who has lesions in their brain, for me to do an open brain biopsy on somebody that is going to die within three months. And I am asking the surgeon to do a risky procedure for them, where you are dealing with bone fragments and everything else.

On a circumstance like that, I think we need to be very honest and say we are putting the health care provider and their family at risk. And we are not really helping the patient. So, in a circumstance like that, I think we have to be very up front about it. Yes, those circumstances arise, but they are not that often.

I don't know if that answered your question, but that is my response.

Q It did. Let's turn the situation around.

For the patient who is dealing with the health care provider, what is your opinion concerning what the patient needs to know about the HIV, AIDS status of the health care provider?

A I think that every patient has a right to know the HIV status of their health care provider. No question about it. If you were going into surgery today, as an example, and you were going to have four vessel bypass and they are going to crack your chest. And there was a vascular surgeon that was HIV infected, I would sit down with you and sayI listen, this is not the person you want to operate on you, because he has a great chance of poking himself. And if he pokes himself or herself, it is very likely that blood is going to drip into your wound and you may become infected.

There was an example that happened at a UCLA affiliate hospital, this was just within the last two years, with Hepatitis B. Where a resident surgeon who had absolutely no symptoms of Hepatitis B, nor did he realize that he even had any injuries during surgery. But a lot of times, you can cut yourself and don't realize it. Gloves are not totally impermeable to blood. There were nineteen cases of somebody who became infected from this one resident surgeon at UCLA with Hepatitis B, all vascular procedures.

Going back to Spain, there was a surgeon in Spain that infected six people with Hepatitis C, doing the same types of procedures. It was felt that probably most of these injuries occurred while closing the chest. When closing the sternum, you have got a lot of bony fragments. It was felt that perhaps some of the bone fragments poked through the gloves, the surgeon bled, even though it wasn't obvious bleeding, it got through the gloves and dripped back into the patient's wound. And that is how they become infected.

So, I would expect that any surgeon that is HIV infected would seriously consider not practicing and not putting other people's lives at risk. Because any percentage chance it

too high. Obviously, we can never get to zero. But, I would advise you, as a patient going through a procedure which carries risks like that, to know the status of your surgeon. And it can be looked at as discriminatory, but I look at it as a public health matter and not as and issue of civil rights, privacy or confidentiality. We are talking about your health and your life.

In my own family, I will share this with you. My cousin came to me, he brought me his aunt, who was from Peru. They couldn't diagnose her, so, he came for a second opinion. He brought her to my office, this was about seven or eight years ago. He asked me what I thought was going on.

When I examined her, the first thing I asked her to do was to open her mouth. She looked like she had terminal cancer. Her mouth was filled with thrush. We did an HIV test on her and she was positive. She had absolutely no risk factors, whatsoever, that we could find. But here she was, she was positive.

Then, we went back and got a little more history. We found out that her husband had open heart surgery in 1982 at Kaiser Hospital in Los Angeles or one of the hospitals down in Los Angeles. He was transfused at that time in 1982. He felt fine after surgery. He recovered very well. In 1987, he started having seizures. They did a brain scan and found multiple lesions in his brain. They assumed it was metastatic cancer and he went on and he died.

Well, in retrospect, she probably got HIV infected from her husband, and he probably didn't have, cancer. He probably had toxoplasmosis of the brain, similar to what Arthur Ashe had. And he probably got it from a transfusion that he had received five years earlier, when he had open heart surgery. So, what I am saying is that risk can happen, that we don't easily identify.

Now, if you become HIV infected from your surgeon and you didn't know it. You felt fine. You are out there

celebrating how well you are doing from your open heart surgery, you might infect your wife or your lover. And then, they now have AIDS. And this is how this disease is spread.

So, it is important for all of us to be. intellectually and morally honest with each other about our HIV status, if we want to control, this disease. So, my answer to you in a very long way like that is that you should know the HIV status of your surgeon.

Q Is there a government or professional regulatory standard in regard to health care professionals that requires them to identify their HIV, AIDS status?

A No. Not that I am aware of. I shouldn't say blankedly, no. I am not aware of that. We are intimidated to do this. But we should be doing it, and if I am the first person to say that, so be it. I want you to know the status of your surgeon, if you are going to have procedure that carries a risk of blood exchange.

Q If the individual health care provider that is in a procedure that involves the risk of some viral exchange, should that person be prohibited from practice?

A No. That person should be prohibited from practicing procedures that endanger others. So, I think the type of practice that they do, would need to be changed. In other words, I would not want a surgeon who is HIV infected, to be doing vascular procedures on somebody that is not infected.

I would also think that if we did appropriate public health, there are many patients that are doing quite well, who are not at the end of their disease, who need procedures done. I have spoken to dentists on this issue. Dentist have told me very clearly, that if they were infected, they would be glad to offer their services to other patients that are infected, so that their colleagues would not have to be unnecessarily exposed.

Now, I know this sound like a pie in the sky, this

kind of thing, but I think that is what we are going to need to do to stop the spread of this disease. Look at Hepatitis B, before we had the Hep B vaccine, 34 percent of oral surgeons came down with Hepatitis B before we had the Hep B vaccine.

These two diseases are spread very similarly. And it is very likely that in time we are going to see more and more dentist that are HIV infected, that didn't know it. And there have been many reported outbreaks of Hepatitis B and Hepatitis C that came at the side of a dental chair. How it happened, whether it was through miss particles, poor hygiene or foul play? I mean, you could name how it might have happened, but many outbreaks have occurred through dentistry.

There is now an outbreak that is reported in New South Wales, Australia, of five people who became infected in a surgi center. There is a report now, from Colombia, the country of Colombia, where 22 percent of patients got infected on a dialysis unit, all from one person. You know, they thought they were engaging in careful hygiene. Before we had the Hep B vaccine, 50 percent of dialysis patients came down with Hepatitis B.

I don't believe that somebody who is HIV infected should be receiving the same dialysis equipment as somebody who is not. If your daughter was on dialysis for kidney failure, I would hope the dialysis unit there would protect her from becoming HIV exposed. And they would do the appropriate measures, they wouldn't say that we can use the same equipment for every one. Unfortunately, they frequently do.

Q You mentioned a situation involving a sumo wrestler, were there was an HIV transmission?

A No, that was Hepatitis B.

Q Hepatitis B?

A Yes.

Q Do you have reference for that?

A I do.

Q What is it?

A I will get it, if you want to hold on a second.

Q Please.

A I happen to have that one here. Mast, is the author, E. D. Mast. It is titled Transmission of Blood Borne Pathogens during Sports, Risk and Prevention, Annals of Internal Medicine, 1995, Vol. 122, pages 283-285.

Now, I am not sure. if that is the reference, but let me give you a couple of others, so you will have them. Reference by an author named J. Karjalainen, Annals of Internal Medicine, October 15, 1995, Vol. 123(8), pages 635-636. I mentioned to you about orienteering, the sport that is done in the Scandinavian region. That reference is by R. Berg, Acta Pathology Microbiology Stand, 1971, Vol. 79, pages 423-427. A similar article to that is in the New England Journal of Medicine, 1967, Vol. 276,pages 540-546.

Another article, in the Lancet, dealing with sports, that is May 1990, Vol. 335, pages 105. There is an article in the Lancet, Transmission of HIV Infection after a fight. This was in the Lancet by O'Farrel, 1992, Vol. 239, page 246. I think that was a different fight one, that was not the one we mentioned. The fight Varese, Italy, the soccer player, was G. Ippolito, JAMA, August 1994, Vol. 272(6), pages 433-434.

There was another article you might find interesting. It was an outbreak of Herpes amongst wrestlers in high school from direct contact with Herpes virus. There is a disease called Herpes Gladiatorum. And Herpes is an infection that wrestlers get from direct skin to skin contact. The article on that is in the New England Journal of Medicine, September 26, 1991, Vol. 325(13), page 906-910.

Hopefully, in those articles, I think you will be able to find some of your answers. The fight that occurred, if

you call Coburn's office. I don't have his number on me, but it is in Washington, DC. He is a Congressman from Oklahoma. And if you call his office and ask for a guy named Roland Foster and ask him to send you the newsletter that discussed the recent reported case of a fight where the glasses broke into the bridge of the guy's nose. I don't know if that has been written up in any medical journal, yet.

MR. RANEY: Dr. Savitch, I am finished. Thank you for your time.

DR. SAVITCH: Your welcome. Stay safe.

MR. COLLIER: Dr. Savitch?

DR. SAVITCH: Yes.

MR. COLLIER: This is Mac Collier. I will give you a call either this weekend or Monday morning. And I sincerely appreciate your time this afternoon.

DR . SAVITCH: Okay.

MR. COLLIER: Thank you.

DR. SAVITCH: Thank you.

COMMONWEALTH OF VIRGINIA,
CITY OF COLONIAL HEIGHTS, to wit:

I, ANNETTE L. IMBRIACO, a Notary Public for the State of Virginia at Large, do hereby certify that the foregoing deposition of CAREY BRUCE SAVITCH was duly sworn to before me at the time and place set out in the caption hereto; further, that the signature of the witness is waived by agreement of counsel and the witness.

Further, that the transcript of the deposition is true and correct, and that there were (0) exhibits filed with me during the taking hereof.

Given under my hand this 16th day of January, 1998.

/s/ Annette L. Imbriaco
ANNETTE L. IMBRIACO
Notary Public for the State of Virginia at Large.

My Commission expires: August 31, 2001